

## **EIGHTH MEETING**

**Friday, 24 May 2013, at 09:40**

**Chairman:** Dr L.G. ROSS (Solomon Islands)  
**later:** Dr W.T. GWENIGALE (Liberia)  
**later:** Dr L.G. ROSS (Solomon Islands)  
**later:** Dr W.T. GWENIGALE (Liberia)

### **1. THIRD REPORT OF COMMITTEE A (Document A66/69)**

Dr CUBA ORÉ (Peru), Rapporteur, read out the draft third report of Committee A.

**The report was adopted.<sup>1</sup>**

### **2. PREPAREDNESS, SURVEILLANCE AND RESPONSE: Item 15 of the Agenda (continued)**

The CHAIRMAN invited the Committee to continue its discussion of the presentations made at the previous meeting on the Middle East respiratory syndrome coronavirus.

Dr MELNIKOVA (Russian Federation) said that the increasing incidence of disease caused by the novel coronavirus was worrying, particularly in view of the forthcoming hajj pilgrimage in Saudi Arabia, and suggested that the Secretariat should provide recommendations for participants, both before and during the pilgrimage.

Professor BAGGOLEY (Australia) asked what additional infection-control measures had been put in place to control the hospital outbreak in Saudi Arabia in April 2013: had they been standard respiratory precautions or had other additional measures been taken? He would also like to know how long the novel coronavirus remained infective.

Dr FUKUDA (Assistant Director-General) said that there was currently no reliable information on the duration of infectivity.

Dr MEMISH (Saudi Arabia) said that his country's National Scientific Committee for Contagious Diseases and National Scientific Committee for Infection Control met every two months in preparation for the annual hajj and issued information on any infectious diseases present in the country or globally. Such recommendations were usually discussed with the Regional Office for the Eastern Mediterranean and with WHO headquarters before they were released.

Regarding the hospital outbreak, he said that the measures applied in the areas where the patients had been clustered, such as the intensive care and haemodialysis units, had included separating and increasing the distance between patients; ensuring good infection-control practices, including droplet and contact precautions; and increasing the number of staff shifts from two to four per day. The hospital outbreak had been halted as a result.

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<sup>1</sup> See page 309.

Dr Yi-Chun LO (Chinese Taipei), noting that phylogenetic analyses had indicated that the novel coronavirus was most similar to a virus found in bats, asked whether any study had looked into circulation of the new virus in bats or other wild animals.

Dr MEMISH (Saudi Arabia) replied that his country's health authorities, working with experts from EcoHealth Alliance and Columbia University, had collected a large number of specimens of bats and other animals, including camels, sheep and cats. To date, only the bat specimens had been sent to laboratories in the United States of America for testing, but authorization had recently been received to ship the other specimens as well.

Dr LOKADI OTETE OPETHA (Democratic Republic of the Congo) asked whether any epidemiological studies had been done to determine the risk factors for infection and thereby enable countries to take preventive action.

Dr MEMISH (Saudi Arabia) said that the apparent risk factors identified to date were male sex, advanced age and an underlying disease such as diabetes, heart disease or kidney disease. Immunocompromised individuals, including those who had undergone a transplant and were receiving immunosuppressive medicines, were also at risk. His country's health authorities were working with the scientific community to examine the potential for using cytokines and other immune modulators in patients.

**Dr Gwenigale took the Chair.**

Mr OVIEDO (Costa Rica) asked if the presentations given by Dr Fukuda and Dr Memish could be made available on the Organization's web site.

Dr FUKUDA (Assistant Director-General) confirmed that the presentations would be posted on the WHO web site.<sup>1</sup>

**Implementation of the International Health Regulations (2005):** Item 15.1 of the Agenda (Documents A66/16 and A66/16 Add.1)

The CHAIRMAN drew attention to the table contained in the annex to document A66/16 Add.1, which replaced the table contained in the annex to document A66/16.

Mr BOYCE (Barbados), speaking on behalf of the member countries of the Caribbean Community, said that the Caribbean subregion faced vulnerabilities related to climate, natural disasters, importation of diseases and problems with respect to the management of chemical and radiological wastes. In order to address current and emerging public health threats, the Caribbean Public Health Agency had been strengthened, with, for example, improved laboratory facilities. Capacity within the Agency could not have been built without the technical and financial support of partners, including PAHO. The WHO Event Information Site and communication from WHO and PAHO to National IHR Focal Points had also been helpful. The establishment of the site was a major accomplishment of the International Health Regulations (2005) and efforts to enhance it should continue.

The Caribbean Community recognized the importance of implementing the Regulations but faced several needs: to increase resource mobilization to fulfil laboratory requirements; enhance capacity to recognize, assess and respond to nuclear events and hazards; train community-based workers to enable them to provide surveillance and response at ports and border crossings; enact

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<sup>1</sup> [http://www.who.int/entity/csr/disease/coronavirus\\_infections/en/](http://www.who.int/entity/csr/disease/coronavirus_infections/en/) (accessed 20 June 2013).

appropriate legislation; and foster greater interministerial commitment to national implementation plans, as health ministries could not fulfil all the requirements of the Regulations on their own. The States Parties to the Regulations in the Caribbean Community would need to request an extension, but with continued support from WHO and other partners they would succeed in meeting the core capacity requirements.

Ms HAGERTY (Ireland), speaking on behalf of the European Union and its Member States, said that Croatia, the former Yugoslav Republic of Macedonia, Montenegro, Iceland, Serbia, Albania, Bosnia and Herzegovina, Ukraine, the Republic of Moldova, Armenia and Georgia aligned themselves with her statement.

Health threats such as the avian influenza A(H7N9) virus and the novel coronavirus were a reminder of the importance of fully implementing the International Health Regulations (2005). The timely, open and comprehensive manner in which the Government of China had communicated information on the avian influenza A(H7N9) virus was commendable. It was essential for States Parties to investigate and share findings on outbreaks promptly, so that other countries could assess and prepare for possible risks to public health.

Noting that core capacities within the European Union would be strengthened by a draft decision on cross-border health threats due to be approved shortly, she affirmed the European Union's willingness to work with the Secretariat in implementing resolution WHA65.23 and its appreciation of the activities already undertaken to strengthen preparedness and response capacities in Member States. She encouraged the Secretariat to continue providing such support, both before and after the 2014 deadline. The WHO Lyon Office had an important role to play in that regard.

Referring to recommendation 13 of the Review Committee on the Functioning of the International Health Regulations (2005), she requested the Secretariat to prepare a short report on the functions of the proposed contingency fund for public health emergencies and on the origin and destination of funds. As to recommendation 5, the Secretariat should strengthen its internal capacity to respond to long-term public health emergencies in a sustained manner. It should also streamline its emergency response and disease surveillance activities. As implementation of the Regulations had been included as a leadership priority for the Organization under the Twelfth General Programme of Work, it would be important to ensure adequate resources for that work.

The European Union strongly supported the comments made by the Director-General at the end of the previous meeting concerning intellectual property restrictions and the sharing of viruses and specimens.

Dr MELNIKOVA (Russian Federation) said that measures taken by WHO to increase technical and financial support to countries with limited capacity and to strengthen their laboratories attested to the broad yet targeted nature of WHO's work to improve implementation of the International Health Regulations (2005) in keeping with the recommendations of the Review Committee. She welcomed the Handbook for Inspection of Ships and Issuance of Ship Sanitation Certificates and the related training opportunities organized by the Secretariat and looked forward to receiving an official translation of the Handbook into Russian in the near future. The new framework for assessing pandemic severity was also welcome. A common approach to assessment would enable countries to respond to outbreaks in a timely and appropriate manner. With regard to enhancement of the WHO Event Information Site, the Secretariat should specify a standard format for data submitted by National IHR Focal Points so as to receive more complete information about events. An important area of work for the Secretariat was monitoring of national capacities and the progress made by States Parties in implementing the Regulations. Her Government, too, was providing assistance on a bilateral basis to countries in the Commonwealth of Independent States, including the supply of equipment, organizational and methodological support, and professional training.

She had not received a clear answer to her earlier question regarding the novel coronavirus and reiterated her request that the Secretariat should provide recommendations for hajj pilgrims.

Dr TRIONO SOENDORO (Indonesia) said that Indonesia was committed to implementing the International Health Regulations (2005) and had established and strengthened its core capacities at various levels. It requested ongoing WHO technical support as it continued its implementation efforts.

Professor ARSLAN (Bangladesh), affirming his Government's commitment to implementing the International Health Regulations (2005), said that Bangladesh had made good progress in capacity-building in several areas. However, its capacity for infection control and prevention, response to potential hazards and relevant activities at points of entry remained insufficient. It would require additional financial, human and material resources in order to enhance those capacities and sought support from the Secretariat for the mobilization of those resources. It would also welcome technical and financial support to improve advocacy among relevant sectors and stakeholders.

Professor SHIRALIYEV (Azerbaijan) said that rapid decision-making and response to public health risks and emergencies of international concern required modern information technologies, such as electronic systems for surveillance of infectious disease. His country's Ministry of Health, in conjunction with international partners, had recently introduced such a system, which provided real-time information on a number of diseases and brought together clinical, epidemiological and laboratory information in a single, integrated database. The system had simplified the exchange of information with other countries and the submission of information to WHO. Azerbaijan stood ready to share its experience with other countries.

Professor BAGGOLEY (Australia) commended the speedy and comprehensive response of the Government of China to the emergence of the avian influenza A(H7N9) virus and the transparent way in which it had shared information on the virus. He also thanked the Government of Saudi Arabia for the information it had provided on the novel coronavirus and encouraged all Member States to be similarly forthcoming, particularly with regard to the coronavirus, about which so little was known. All States Parties should prioritize action on the International Health Regulations (2005) in order to ensure full implementation by 2016.

Dr DAULAIRE (United States of America), observing that there was no better evidence of the value of the International Health Regulations (2005) than the response to the recent emergence of the avian influenza A(H7N9) virus, commended the openness and transparency demonstrated by the Government of China. The global community was not yet where it should be with respect to implementation of the Regulations, however. States Parties had a binding obligation to meet their commitments under the Regulations, and it was critical for global health that they did so. The recent WHO-sponsored regional workshops had been valuable for identifying gaps and needs for full implementation of the Regulations and for planning future support and technical cooperation. The Secretariat had a central role to play in assessing States Parties' public health capacities, providing and facilitating technical cooperation, and mobilizing financial resources to support developing countries in implementing the Regulations. His Government would continue to provide assistance for those efforts when requested.

Dr JACOBS (New Zealand) expressed support for the criteria proposed by the Secretariat for the granting of an additional extension for implementation of the International Health Regulations (2005) and endorsed the principle that the criteria should not unduly hinder countries from obtaining an extension. He also strongly supported the proposal to focus support on the countries that faced the greatest difficulties in developing their core capacities, as those capacities were fundamental to the effective management of public health risks and to implementation of both the spirit and the letter of the Regulations. He recognized the constraints faced by very small States, particularly Pacific island States, in implementing the requirements of the Regulations and encouraged the Secretariat and other development partners to continue supporting them to that end. With regard to recommendation 3 of the Review Committee, he looked forward to the dissemination of draft standard operating procedures for

monitoring international travel and trade measures during public health events and emergencies. He joined others in commending the efforts and transparency of the Government of China in responding to the avian influenza A(H7N9) virus and thanked the Government of Saudi Arabia for the information provided on the novel coronavirus.

Mrs OGU (Nigeria), speaking on behalf of the Member States of the African Region, said that, in implementing the recommendations of the Review Committee, it was important to be mindful of national sovereignty and integrity. It was also important to ensure that national IHR Focal Points were afforded adequate resources and authority. The States Parties in Africa were working hard to develop the core capacities and, with sufficient continued support from WHO, most were expected to be able to meet the requirements by 2014. Nevertheless, the Region welcomed the provision for an extension of the deadline beyond 2014 and had no objection to the proposed criteria. Support and incentives should be provided to countries not able to meet the requirements of the Regulations within the anticipated timeframe. Meeting reporting requirements under the Regulations had proved a challenge for some countries in the Region, and she therefore called on the Secretariat to provide more focused attention, support and resources to the African States Parties for that purpose, in particular to enable them to enhance monitoring of progress on core capacity development so as to ensure that reporting requirements for 2013–2014 were met.

Dr ABDULLA (Maldives), speaking on behalf of the Member States of the South-East Asia Region, said that the International Health Regulations (2005) had played a crucial role in enabling countries to respond to public health emergencies of international concern. All States Parties in the Region had been granted extensions to 2014 for implementation of the core capacity requirements and were working towards that goal, but capacity gaps persisted in the areas of health legislation, points of entry, surveillance, laboratory capacity, and, especially, human resource development. Fulfilling the requirements necessitated the development of policies and interventions outside the health sector, which in turn required multisectoral commitment and collaboration at all levels. WHO's support for building capacity and collaboration with stakeholders in other sectors was much appreciated.

The countries of the Region appreciated the proposed criteria for the granting of extensions beyond 2014. Nevertheless, as South-East Asia was a hotspot for emerging and re-emerging diseases such as avian influenza A(H5N1) and drug-resistant malaria, and as a lack of capacity could threaten both regional and global health security, the countries of the Region were committed to getting their core capacities in place as soon as possible. They were concerned, however, that the reduction in the Region's allocation under the Programme budget 2014–2015 would significantly hinder their ability to do so. She appealed to WHO and other partners to provide the States Parties in the Region with the fullest possible support. All Member States and the Secretariat should continue to strengthen advocacy among, and collaboration with, technical and financial partners in order to identify institutional, human resource, and financial gaps and to mobilize resources accordingly.

Dr BARBOSA (Brazil) said that the emergence of the novel coronavirus and the avian influenza A(H7N9) virus had highlighted the need to strengthen core capacities in every country. It was important to recognize the importance of the International Health Regulations (2005) as an effective platform for ensuring transparency and solidarity in the face of threats to global health security. His country would continue to work towards implementation of the Regulations and support other countries through South–South cooperation. The Ministry of Health of Brazil, in collaboration with PAHO and other partners in the Americas, was in the process of producing Spanish and English versions of a web-based tool for monitoring public health events that would help to enhance the surveillance capacity of National IHR Focal Points.

Concerning the reference in the report to areas at risk of yellow fever transmission, the Secretariat should continue its efforts to update information on the level of risk and should also consider assessing whether, in the current epidemiological situation, requiring proof of vaccination

was effective in protecting against the international spread of the disease. His country stood ready to collaborate in that work.

Dr SADRIZADEH (Islamic Republic of Iran) said that the Secretariat's efforts to enhance laboratory quality systems should continue, because strengthening laboratory capacity for the detection of pathogens that were a threat to human and animal health was a priority. It was particularly important at a time when emerging infectious diseases and pathogens such as new strains of human influenza virus and the novel coronavirus threatened human security at the global, regional and national levels. It was also essential to strengthen core surveillance capacities, improve intersectoral coordination and cooperation and ensure support for regulatory systems, allocation of adequate resources and timely notification of events of international concern.

Dr AFZAL (Pakistan) said that her country was fully committed to implementing the International Health Regulations (2005) and to that end was applying the WHO guidelines on issuance of health certificates and ship sanitation control certificates. Monitoring and surveillance systems were in place at all entry points to prevent cross-border transmission of disease, and five border vaccination posts had been set up. Efforts were continuing to prevent the transmission of yellow fever. Further work was needed with regard to resource mobilization, laboratory networks, early warning systems, and preparedness for public health professionals in order to implement the Regulations fully and build on the recommendations contained in the report.

Ms REITENBACH (Germany), expressing gratitude to the Government of China for its timely sharing of information on the avian influenza A(H7N9) virus, said that the emergence of that virus and the novel coronavirus had underscored the importance of fully implementing the International Health Regulations (2005) and of outbreak investigation procedures, evidence-based responses and full information-sharing. Member States should provide adequate training and resources to enable personnel to carry out those tasks. It was crucial to share best practices and lessons learnt in identifying gaps and fulfilling core capacity requirements. Her Government would gladly share its experience in strengthening biological safety and security, diagnostics and detection, surveillance and other aspects of core capacity implementation. It was pleased to contribute €500 000 to support the Organization's response to the avian influenza A(H7N9) virus and the novel coronavirus.

Dr BEN MAMOUN (Morocco) noted that it was evident from the table contained in document A66/16 Add.1 that much remained to be done in order to ensure that the necessary core capacities existed in all countries. The fact that some States Parties had not submitted data for 2012 might indicate that greater effort was needed in order to achieve expected results. With regard to the proposed criteria for the granting of extensions to 2016, he favoured their review by the regional committees and the subsequent submission of revised criteria to the Executive Board at its 134th session in 2014.

Dr RUÍZ MATUS (Mexico) said that his country was working to implement the International Health Regulations (2005), with particular emphasis on surveillance, and noted the need for multisectoral coordination. He thanked the Secretariat for its continued support to Member States and urged Member States to continue working with the Secretariat to ensure a better global response to health emergencies. Expressing his appreciation for the presentations on the avian influenza A(H7N9) virus and the novel coronavirus, he endorsed the comments made by the Director-General at the end of the previous meeting.

Ms BELL (Canada) said that Canada supported the development of standard operating procedures for monitoring international travel and trade during public health events and emergencies in order to help ensure that decisions were based on evidence and that timely and consistent information was conveyed to the public. She encouraged the Secretariat to continue its efforts to

improve communications in future emergencies. Some countries continued to face challenges in implementing the International Health Regulations (2005) and further extensions of the deadline for meeting core capacity requirements would likely be sought after the expiry of the first two-year extension in 2014. She supported the proposed criteria for extensions and hoped that Member States and international actors would offer the support needed by the countries that faced the greatest obstacles in meeting their obligations. She commended the Government of China's response to the avian influenza A(H7N9) outbreak and thanked the delegate of Saudi Arabia for the information provided on the novel coronavirus.

Dr DAKULALA (Papua New Guinea) expressed appreciation for the support his country had received from WHO and other partners for the implementation of the International Health Regulations (2005) and for the response to various natural disasters and health emergencies. Papua New Guinea would continue to work with the Secretariat to implement the recommendations of the Review Committee and would submit updated information to supplement that contained in document A66/16 Add.1.

Dr AL-JALAHMA (Bahrain), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that regulatory and human resource capacities remained inadequate. Capacity for self-assessment and monitoring of implementation of the International Health Regulations (2005) also needed strengthening. The impact of those weaknesses in the countries of the Eastern Mediterranean Region included failure by National IHR Focal Points to report events and delayed reporting on such matters as the implementation of control measures. The crises and instability in some countries of the Region had negatively affected capacity-building efforts and jeopardized their sustainability. Additional technical and financial support was needed to enable those countries to implement the core capacities, particularly with respect to points of entry and surveillance. She called on Member States to provide that support.

Dr SEAKGOSING (Botswana) said that Botswana had incorporated the International Health Regulations (2005) into its national legislation and had designated points of entry. Terms of reference and tools for national core capacity assessment had been developed and would be applied in order to gain an understanding of existing capacity and obtain baseline information for the formulation of a national strategy and plan of action for implementation of the Regulations. Botswana would require technical and financial support from WHO in order to carry out the assessment and develop the strategy, draw up a strategic plan for public health emergency preparedness and response, put in place standard operating procedures for port health, ensure cross-border collaboration and strengthen human resource capacity.

Dr DARIN AREECHOKCHAI (Thailand), acknowledging the proposed criteria for extensions, said that accelerating the implementation of the International Health Regulations (2005) would require strengthening of core capacities in sectors other than the health sector. Accordingly, she called on the Director-General to act as an advocate for implementation of the Regulations and development of the core capacities in relevant ministerial meetings. In addition, the Secretariat should develop practical international guidelines to support implementation of the Regulations – for example, guidelines on quarantine at points of entry, international contact-tracing and isolation of individuals with serious communicable disease. Such high-level policy advocacy and practical guidelines would help National IHR Focal Points to carry out their mandates.

Mr OVIEDO (Costa Rica), affirming his support for the comments made by the Director-General at the end of the previous meeting, said that his Government had decided not to request a deadline extension, thereby exerting pressure on relevant local stakeholders to establish all the core capacities. In the current year, it had conducted simulation exercises at ports, using a guide developed at the national level. Similar guides were being prepared for conducting simulation exercises at ground

crossings and airports, including some international airports not designated under the Regulations. Protocols for managing encephalitis and chemical and radiological events were being finalized. Costa Rica was providing technical advice and support to countries that had requested an extension of the implementation deadline.

Dr MARTÍNEZ DE CUELLAR (Paraguay) said that her country, having requested an extension of the implementation deadline, was working to improve its core capacities at entry points and with respect to diagnosis and surveillance. With support from PAHO, Paraguay had succeeded in strengthening its detection, reporting and response capacities and its epidemiological surveillance system, which in turn had enhanced the quality of the national information system. As a result, near real-time public health information was available to national decision-makers and the international community, including that related to acute events with epidemic potential. The seasonal behaviour of influenza viruses had afforded an opportunity to learn from successive outbreaks and to improve preparedness. One of the lessons learnt had been that action was needed on several fronts: for example, it would do little good to increase the number of sentinel sites if there was insufficient capacity to diagnose the pathogens found to be in circulation. Multisectoral and multidisciplinary action was also needed.

In preparation for the winter influenza season and in response to the emergence of the novel coronavirus and the avian influenza A(H7N9) virus, detection, alert and response coordination capacities had been strengthened and hospital personnel had been alerted to the need to investigate any severe acute respiratory infection of unknown etiology. Access to health services had also been increased.

Ms POLACH (Argentina) said that the annex to document A66/16 should be removed because, although the assessment tools used to produce the data were useful to States Parties internally, they were not designed to be used for purposes of international comparison. Her Government requested that it be permitted to submit reports relating to part B of Annex 1 of the Regulations to the World Health Assembly in the format used by MERCOSUR, as was its prerogative as a State Party. It also requested the Secretariat's cooperation in harmonizing the requirements of WHO with those of the International Civil Aviation Organization, in keeping with the provisions of the International Health Regulations (2005).

Referring to paragraph 23 of document A66/16, she emphasized that all WHO's guidance documents should be made available in Spanish and that Member States should be involved in their preparation. She asked for clarification of the format of the progress report referred to in paragraph 31. Regarding the proposed criteria for extensions, she supported the suggestion by the Executive Board that they should be discussed by the regional committees and then resubmitted in final form to the Board in 2014. The ultimate aim of the criteria should be to ensure support for and avoid stigmatization of Member States that had been unable to meet the capacity requirements within the expected timeframe.

She asked for more information on how the Secretariat was supporting Member States in assessing the risk of yellow fever transmission.

Dr LEI Zhenglong (China) said that the International Health Regulations (2005) were a useful platform for organizing international capacity to respond to global public health challenges, such as the avian influenza A(H5N1) and avian influenza A(H7N9) viruses. In order to enhance preparedness for the future emergence of viruses and other pathogens with pandemic potential, he suggested establishing a joint information-sharing mechanism.

Dr SA'A (Cameroon), noting the proposed extension criteria, affirmed his Government's commitment to full establishment of the required national capacities for surveillance and response and asked for the Organization's support for that purpose.



Dr AL-TAAE (Iraq) said that the International Health Regulations (2005) were being severely tested by the emergence of the novel coronavirus and the avian influenza A(H7N9) virus and other challenges, including infections with Ebola virus and the pandemic A(H1N1) 2009 virus. Those challenges, which should be approached as a package, could only be met by putting in place a strong organizational structure at the national level and by ensuring effective intersectoral and interministerial collaboration. It was also necessary to work with civil society. WHO had a crucial role to play in capacity-building at country level. Its efforts in that regard should not be restricted to ministries of health but should also include other ministries and civil society organizations. The Organization also had an important role to play in ensuring the availability of diagnostic kits for the novel coronavirus and other viruses and preventing their monopolization by certain companies. Access to such kits was essential to effective epidemiological and laboratory surveillance. It was also important to carry out joint research with other countries and within the Evidence-Informed Policy Network (EVIPNet) at the regional level.

Dr Jen-Hsiang CHUANG (Chinese Taipei) said that Chinese Taipei's success in meeting the core capacity requirements established in Annex 1 of the International Health Regulations (2005) had been verified in March 2013 by experts from Australia. Chinese Taipei had listed human infection with avian influenza A(H7N9) virus as a notifiable disease and on 24 April 2013 had confirmed the first human case, which it had reported to WHO within 24 hours.

Chinese Taipei supported the Secretariat's efforts to develop a framework for assessing pandemic severity. Given the lack of data and level of uncertainty early in a pandemic, a phased approach would be advisable. He encouraged the Secretariat to test the framework during seasonal influenza outbreaks, organize data collection at the global level and develop pre-pandemic guidance based on proposed measures that could serve as a reference for decision-makers. Chinese Taipei would continue to collaborate with WHO under the International Health Regulations (2005) with a view to enhancing global public health security.

Dr FUKUDA (Assistant Director-General) noted the broad support for the International Health Regulations (2005) and agreed that recent challenges such as the avian influenza A(H7N9) virus and the novel coronavirus had demonstrated their importance. Several comments had been made on core capacities, requests for extensions and the criteria for extensions after 2014. Those comments had reflected a clear sense of urgency about the need to develop the core capacities, for which purpose many States Parties had requested the Secretariat's support. With regard to the criteria for extensions, he recalled that they had been introduced at the Executive Board during its 132nd session in 2013 and would be considered by the regional committees before being finalized by the Secretariat. As to support currently being provided by the Secretariat to facilitate implementation of the Regulations, it had taken several forms, including the organization of regional meetings, two of which had taken place in the African Region, which had brought together Member States, donors and technical agencies to identify needs and potential support. One of the main aims had been to foster cohesion and coordination in order to avoid both overlap and gaps in support. In several instances, the Secretariat had provided direct support through guidance and training. Those activities would continue. However, it had to be recognized that the Secretariat could not provide technical support and carry out its coordination functions without funding. The Secretariat was working hard to mobilize the necessary resources, but it was often difficult to raise a sufficient amount.

Turning to specific comments by Member States, he would provide information on the format for reporting progress in developing core capacities directly to the delegation of Argentina. He undertook also, as requested by the delegate of Ireland, to provide a short report on the proposed contingency fund for public health emergencies. The delegate of the Russian Federation had asked about translation of documents into the Russian language; that was an example of how lack of funding could limit the Secretariat's ability to provide services to Member States. When funds were limited, activities had to be prioritized, and unfortunately that sometimes meant that translation was delayed. The Secretariat would continue striving to ensure that documents were translated and made available

as quickly as possible. He welcomed Azerbaijan's introduction of a single electronic database. Such databases were ideal for purposes of data collection and monitoring at the national, regional and international levels. However, in the context of WHO, it was important to ensure that such systems were globally applicable and useable in all countries.

Regarding travel recommendations for hajj pilgrims, he noted that making such recommendations was one of the Secretariat's most difficult tasks. Certainly, he and his staff wished to take all necessary measures to prevent the spread of disease, but they also recognized that travel was the lifeblood of many countries. To date, the Secretariat had not issued any travel advisories relating to either the avian influenza A(H7N9) virus or the novel coronavirus; however, the situation was being monitored closely and recommendations would be issued if appropriate. Additional experts would be called upon if required, as provided for under the International Health Regulations (2005).

The issues surrounding yellow fever, like those relating to travel recommendations, were complex. The International Health Regulations (2005) called for identification of areas at risk of yellow fever, which had led some countries to believe that they were unfairly being held accountable for yellow fever, particularly when only certain areas within their borders were at risk. Nationals from those countries might also face travel restrictions. Although the Strategic Advisory Group of Experts on immunization had recently determined that a single dose of vaccine would confer lifelong immunity against the disease, it would be for governments to decide whether they accepted a single dose as proof of immunity. A third issue was the duration of risk, which was determined by analysing all available information. Unfortunately, however, the available information was sometimes old or limited. He encouraged any Member State with specific queries relating to yellow fever to contact the IHR secretariat.

The delegate of Canada had referred to strengthening of core capacities relating to communications. In that connection he noted that the Pandemic Influenza Preparedness Framework and the International Health Regulations (2005) both focused on bolstering communications. The Secretariat was seeking to harmonize its approach to the implementation of those two frameworks so as to ensure adequate attention to communications while avoiding duplication of work. As recommended by the delegate of Thailand, the Secretariat was striving to raise high-level political awareness of the Regulations, while providing practical guidance aimed at facilitating their implementation. The suggestion made by the delegate of Iraq that WHO provide a package for dealing with a variety of pathogens was worth exploring, although it might prove difficult to translate the idea into practice, particularly as a large number of laboratories would have to be involved.

The DIRECTOR-GENERAL thanked Member States for supporting her proposal of the previous day to investigate the facts regarding the novel coronavirus. It was essential to identify and address any barriers that might prevent Member States from implementing the International Health Regulations (2005), including barriers that impeded timely submission of information to the Secretariat and the Secretariat's subsequent sharing of the information with other Member States. It was also important to determine how the Secretariat could better support countries in channelling specimens of viruses or any new or emerging pathogens through WHO collaborating centres to laboratories with appropriate capacity. No WHO collaborating centre would ever use intellectual property rights to prevent the sharing of information or to hinder or delay the development of diagnostic tests. If it did, it would not be eligible to be a WHO collaborating centre, a designation that was not easily earned. Unlike commercial laboratories, laboratories that were WHO collaborating centres were subject to Member State oversight. She reiterated her pledge to scrutinize any barriers to information- and virus-sharing and report back to Member States on how the Secretariat could better support them in that regard.

The role of WHO was to work with Member States in implementing the International Health Regulations (2005). That role was essential because new and emerging infections were a global problem, not limited to one country, and a coordination mechanism was required in order to bring together the world's assets and determine whether any new pathogen would pose a public health risk of international concern. In that connection, the Secretariat would follow up on the suggestion by the

delegate of Iraq for the provision of guidance on dealing with multiple pathogens. It would also organize joint missions as soon as possible to carry out fact-finding and risk assessment in Saudi Arabia and other countries affected by the novel coronavirus in order to gain greater clarity regarding the incubation period, signs and symptoms and proper clinical management of the disease and to determine whether any specific travel advice was needed. She recognized the urgency of providing accurate information and appropriate advice, especially in the case of Saudi Arabia, given the imminence of the hajj. She affirmed that the Secretariat was not currently recommending screening at airports or other points of entry, nor had it recommended any travel restrictions.

The International Health Regulations (2005) provided a legal framework for strengthening the global defence system against new and emerging infections, but as Dr Fukuda had said, it could not operate effectively without funding. She appreciated the funding already pledged by the Governments of Australia, China, France, Germany, the United States of America and other countries and appealed to other governments, particularly that of Saudi Arabia, also to support the Secretariat's work on the Regulations, which offered a prime example of a critical programme area that should never be left unfunded.

**The Committee noted the report.**

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

**Draft comprehensive mental health action plan 2013–2020:** Item 13.3 of the Agenda (Documents A66/10 Rev.1 and A66/10 Rev.1 Add.1) (continued from the fourth meeting, section 2)

The CHAIRMAN drew attention to a revised version of the draft resolution containing the draft comprehensive action plan, which incorporated amendments proposed by several Member States.

Mr THOMSON (Switzerland), expressing support for the draft action plan proposed by the Secretariat, requested that the Committee consider each proposed amendment contained in the revised draft resolution one at a time. He further suggested that the Member State that had initially proposed each amendment should indicate whether it still wished the amendment to be included.

Dr ARMSTRONG (Secretary) read out the following proposed amendment to paragraph 2 of the draft resolution:

2. URGES Member States to implement proposed actions for Member States in the comprehensive mental health action plan 2013–2020 **as adapted to national priorities and specific national circumstances [Sweden] ensuring that sufficient domestic resources are available especially in developing countries [Paraguay];**

Dr MARTÍNEZ DE CUELLAR (Paraguay) said that her delegation had consulted technical experts; paragraph 36 of the draft action plan, as contained in the Annex to the draft resolution, should adequately ensure the allocation of a budget for implementation of the action plan. She therefore withdrew her delegation's proposed amendment to paragraph 2 of the draft resolution.

The CHAIRMAN said that, in the absence of any objection, he would take it that the Committee accepted paragraph 2 of the draft resolution, as amended.

**It was so agreed.**

Dr ARMSTRONG (Secretary) read out the following proposed amendment to paragraph 20 of the Annex to the draft resolution:

20. The **vision** of the action plan is a world in which mental health is valued, ~~and~~ promoted **and protected [Trinidad and Tobago]**, mental disorders are prevented and persons affected by these disorders are able to exercise the full range of human rights and to access high-quality, culturally-appropriate health and social care in a timely way to promote recovery, all in order to attain the highest possible level of health and participate fully in society and at work free from stigmatization and discrimination.

Mrs HARDING-ROUSE (Trinidad and Tobago) said that she wished to retain the amendment. It favoured the addition of “and protected”, as it highlighted the need to ensure the enactment of legislation to protect the human rights of persons with mental disorders.

The CHAIRMAN said that, in the absence of any objection, he would take it that the Committee accepted the amendment.

**It was so agreed.**

Dr ARMSTRONG (Secretary) read out the following proposed amendment to paragraph 21 of the Annex to the draft resolution:

21. Its overall **goal** is to promote mental well-being, prevent mental disorders, provide care, enhance recovery, promote human rights and reduce the mortality, morbidity and disability for persons with mental disorders **in accordance with definition mentioned in paragraph 5. [Bangladesh]**

Professor ARSLAN (Bangladesh) affirmed that he wished to retain the proposed amendment.

Mr THOMSON (Switzerland), noting the importance of paragraph 21, pointed out that the definition contained in paragraph 5 was explicit and would clearly apply to the entire plan. In his opinion, paragraph 21 would be more elegant without a reference to another paragraph.

Professor ARSLAN (Bangladesh) said that the aim of the proposed amendment had been to draw attention to autism, which was a source of growing concern globally. However, after further consideration, he believed that the reference to the disease in paragraph 5 was sufficient and therefore withdrew the proposed amendment to paragraph 21.

Dr ARMSTRONG (Secretary) read out the following proposed amendment to *Global target 3.1*, which followed paragraph 72 in the Annex to the draft resolution and also appeared in Appendix 1:

*Global target 3.1: 80% of countries will have at least two functioning national, **large scale [Trinidad and Tobago]** multisectoral promotion and prevention programmes in mental health (by the year 2020).*

Mrs HARDING-ROUSE (Trinidad and Tobago) said that, following consultation with other Member States, she had decided to withdraw the proposed amendment.

Dr ARMSTRONG (Secretary) read out the following proposed amendment to the indicator under *Global target 3.2* as contained in the second table under Objective 3, in Appendix 1 to the Annex to the draft resolution:

<b>Global target 3.2</b>	The rate of suicide in countries will be reduced by 10% (by the year 2020).
Indicator	Number of <del>completed</del> suicides <b>deaths [USA]</b> per year per 100 000 population.

Ms BURRIS (United States of America) said that she wished to retain the amendment. It was preferable to refer to “suicide deaths” rather than to “completed suicides”, which might be construed to mean “successful suicides”.

The CHAIRMAN said that, in the absence of any objection, he would take it that the Committee accepted the amendment.

**It was so agreed.**

Mrs HARDING-ROUSE (Trinidad and Tobago) suggested that, in the first bullet point under “Options for implementation” under Objective 3 in Appendix 2 to the Annex to the draft resolution, the phrase “programmes to improve mental health literacy and” should be inserted between “through” and “media”.

Mr THOMSON (Switzerland) said that the term “mental health literacy” was difficult to understand in French; moreover, the concept was largely covered by the phrase “increasing public knowledge and understanding about mental health”. In the interests of simplicity and elegance of language, he would therefore suggest retaining the original wording.

Mrs HARDING-ROUSE (Trinidad and Tobago) said that, as the amendment she had proposed would not change the meaning of the paragraph significantly, she was happy to withdraw it.

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

**The draft resolution, as amended, was approved.<sup>1</sup>**

**Disability:** Item 13.5 of the Agenda (Documents A66/12 and EB132/2013/REC/1, resolution EB132.R5) (continued from the fifth meeting, section 1)

The CHAIRMAN drew the Committee’s attention to a revised version of the draft resolution contained in resolution EB132.R5, which incorporated amendments by Member States and which read:

The Sixty-sixth World Health Assembly,

**PP1** Having considered the report on disability;<sup>2</sup>

**PP2** Recalling resolution WHA58.23 on disability, including prevention, management and rehabilitation;

**PP3** Recalling the Convention on the Rights of Persons with Disabilities, signed by 155 countries and regional integration organizations and now ratified by 127, which highlights that disability is both a human rights issue and a development issue and, for States Parties, recommends that national policies and international development programmes are inclusive of and accessible to persons with disabilities;

**PP4** Recalling United Nations General Assembly resolutions calling for the mainstreaming of disability in the development agenda (64/131 on realizing the Millennium Development Goals for persons with disabilities, 65/186 on realizing the Millennium Development Goals for persons with disabilities towards 2015 and beyond, and 66/229 on the Convention on the Rights of Persons with Disabilities and the Optional Protocol thereto);

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<sup>1</sup> Transmitted to the Health Assembly in the Committee’s fourth report and adopted as resolution WHA66.8.

<sup>2</sup> Document EB132/10.

resolution 66/288 endorsing the outcome document of the United Nations Conference on Sustainable Development; and resolution 66/124 deciding to convene a High-level Meeting of the General Assembly on the realization of the Millennium Development Goals and other internationally agreed development goals for persons with disabilities;

**PP5** Recognizing existing national and regional efforts to facilitate the enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity;

**PP6** Welcoming the first *World report on disability*,<sup>1</sup> which is based on the best available scientific evidence and which shows that many of the barriers people with disabilities face are avoidable and that the disadvantage associated with disability can be overcome;

**PP7** Noting that an estimated 1000 million people live with disabilities; that this number is set to increase as populations age, the prevalence of chronic health conditions rises and in response to trends in environmental and other factors; that disability disproportionately affects vulnerable populations, notably women, older people and poor people; that low-income countries have a higher prevalence of disability than high-income countries; and that people with disabilities, particularly those in developing countries, experience poorer health than people without disabilities, higher rates of poverty, lower rates of educational participation and employment, increased dependency and restricted participation, and higher rates of violence and abuse than non-disabled people;

**PP7bis** Noting also that there are differences between physical disability and disability arising out of mental illness, including autism, particularly in the ways in which the disability impacts on the persons concerned, their families and caregivers, and in the varying requirements of treatment and care involved; [Nepal on behalf of SEAR]

~~PP7bis Noting also that there are differences between physical disability and disability arising out of mental illness, including autism, particularly in the ways in which the disability impacts on the persons concerned, their families and caregivers, and in the varying requirements of treatment and care involved; [USA]~~

**PP8** Recognizing the responsibility of Member States to take appropriate measures to ensure equal access to health services and care for persons with disabilities **through universal health coverage** [Nepal on behalf of SEAR];

**PP9** Recognizing that people with disabilities have the same need for general health care as non-disabled people, yet have been shown to receive poorer treatment from health care systems than non-disabled people;

**PP10** Recognizing the important role that formal and informal caregivers play in supporting persons with disabilities and that, although informal caregivers cannot replace the role of the national and local authorities, they do need particular attention from the authorities to help them with their tasks, and noting that **their both formal and informal caregivers'** [Nepal on behalf of SEAR] role is increasing in the context of the sustainability of health systems and the ageing of the population;

**PP11** Also recognizing the extensive unmet needs for habilitation and rehabilitation services, which are vital to enable many people with a broad range of disabilities to participate in education, the labour market, and civic life, and, further, that measures to promote the health of people with disabilities and their inclusion in society through general and specialized health services are as important as measures to prevent people developing health conditions associated with disability;

**PP12** Acknowledging that a comprehensive multisectoral approach is required to meet the multiple barriers faced by persons with disabilities and that mainstreaming disability in development is the most efficient and cost-effective way of meeting the needs of people with disabilities;

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<sup>1</sup> World Health Organization, World Bank. World report on disability. Geneva: World Health Organization; 2011.

**PP13** Welcoming the work of WHO's Task Force on Disability to raise awareness of disability as a cross-cutting issue in WHO's technical work, and in removing physical, information and policy barriers to the participation of people with disabilities in WHO's work,

1. ENDORSES the recommendations of the *World report on disability*, which offer strategies for the implementation of the Convention on the Rights of Persons with Disabilities;
2. URGES Member States:<sup>1</sup>
  - (1) to implement as States Parties the Convention on the Rights of Persons with Disabilities;
  - (2) to develop, **as mentioned in Article 5 of the Convention [Nepal on behalf of SEAR]** as appropriate, plans of action, in close consultation with and active involvement of persons with disabilities, including children with disabilities, through their representative organizations, so that different sectors and different actors can coordinate effectively to remove barriers and enable persons with disabilities to enjoy their human rights **and improve their quality of life; [Viet Nam]**
  - (3) ~~to gather appropriate sex- and age-disaggregated data~~ **to establish and strengthen monitoring and evaluation system [Nepal on behalf of SEAR]** on disability, including prevalence, needs and unmet needs, direct and indirect costs, barriers and quality of life, using the International Classification of Functioning, Disability and Health, and effective programmes and good practices developed in different regions in order to ensure that data are nationally relevant and internationally comparable;
  - (4) to work to ensure that all mainstream health services are inclusive of persons with disabilities, an action that will necessitate, inter alia, adequate financing, **social protection, [Viet Nam]** comprehensive insurance coverage, accessible health care facilities, services and information, and training of health care professionals, in order to respect the human rights of persons with disabilities and to communicate with them effectively;
  - (5) to promote the receipt by informal caregivers of appropriate support in supplementing the services provided by health authorities;
  - (6) to promote habilitation and rehabilitation across the life-course and for a wide range of health conditions through: early intervention; integrated and decentralized rehabilitation services, including mental health services; improved provision of wheelchairs, hearing aids, low vision devices and other assistive technologies; and training to ensure a sufficient supply of rehabilitation professionals to enable people with disabilities to achieve their potential and have the same opportunities to participate fully in society;
  - (7) to promote and strengthen **integrated [USA]** community-based ~~rehabilitation programmes~~ **supports and services [USA]** as a multisectoral strategy that empowers all persons with disabilities to access, benefit from, and participate fully in **inclusive [USA]** education, employment, and health and social services;
  - (8) ~~to prevent discriminatory denial of health care or health services on the basis of disability in order to promote equality;~~ **to consider providing health services to the persons with disabilities as an investment rather than expenditure; it will reduce discrimination and denial, and increase respect for the rights of persons with disabilities; [Nepal on behalf of SEAR]**

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

3. REQUESTS the Director-General:
  - (1) to provide **technical and financial [Viet Nam]** support to Member States in implementing the recommendations of the *World report on disability*;
  - (2) to provide support to Member States, and intensify collaboration with a broad range of stakeholders including organizations of the United Nations system, academia, the private sector and organizations of persons with disabilities, in the implementation of the Convention on the Rights of Persons with Disabilities, in particular Articles 16 (Freedom from exploitation, violence and abuse), 19 (Living independently and being included in the community), 20 (Personal mobility), 25 (Health), 26 (Habilitation and rehabilitation) and 31 (Statistics and data collection) across the global health agenda;
  - (3) to ensure that the health needs of children and adults with disabilities are included in WHO's technical work on, inter alia, child and adolescent health, sexual, reproductive and maternal health, long-term care for older people, care and treatment of noncommunicable conditions, work on HIV/AIDS and other communicable diseases, emergency risk management, and health system strengthening;
  - (4) to ensure that WHO itself is inclusive of people with disabilities, whether they be visitors, collaborators or employees, by continuing to create accessible premises and information, ~~providing reasonable accommodation,~~ **[Viet Nam]** and by ensuring that people with disabilities are consulted closely and involved actively through their representative organizations wherever necessary and appropriate;
  - (5) to support and participate in the High-level Meeting of the United Nations General Assembly on the Realization of the Millennium Development Goals and Other Internationally Agreed Development Goals for Persons with Disabilities, and efforts to include disability in the post-2015 development agenda by drawing attention to disability data, ~~and health,~~ **supports and services, [USA] and health** and rehabilitation needs and related responses;
  - (6) to prepare, in consultation with other organizations of the United Nations system **and Member States [Nepal on behalf of SEAR]** and within existing resources, a comprehensive WHO action plan with measurable outcomes, based on the evidence in the *World report on disability*, in line with the Convention on the Rights of Persons with Disabilities and the report of the High-level Meeting of the United Nations General Assembly on Disability "The way forward: a disability-inclusive development agenda towards 2015 and beyond" for consideration by Member States at the Sixty-seventh World Health Assembly, through the Executive Board.

Dr VALLEJO (Ecuador) said that he had discussed the amendments that had been proposed with interested Member States, including those that had proposed amendments to the original draft resolution, and it had been agreed that preambular paragraph 7*bis* should be deleted and that a new preambular paragraph 7*bis* should be inserted, to read: "Further recalling that, according to the Convention on the Rights of Persons with Disabilities, persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments, which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others". In the eighth preambular paragraph, it was proposed to insert "ideally" after the phrase "for persons with disabilities". It was also proposed to insert a new eleventh preambular paragraph, to read: "Acknowledging that providing universal access to health care and health services is an investment for society."

In subparagraph 2(2), it was proposed to remove "as mentioned in Article 5 of the Convention" after "to develop". In subparagraph 2(3), it was proposed to insert "with the goal of gathering appropriate sex- and age-disaggregated data, as well as other relevant information" after "monitoring and evaluation system". It was further proposed that subparagraph 2(8) should be amended to read: "to prevent discrimination in access to health care or health services in order to promote equality".



In subparagraph 3(1) it was proposed to delete “and financial”, after “to provide technical”. In subparagraph 3(4), it was proposed to insert “providing reasonable accommodation” after “premises and information”, and in subparagraph 3(6) it was proposed to reinstate the previously deleted footnote after “Member States”, which read: “And, where applicable, regional economic integration organizations”.

**Dr Ross resumed the Chair.**

Dr CHAND (Nepal), speaking on behalf of the Member States of the South-East Asia Region, supported the amendments as read out by the delegate of Ecuador.

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

**The draft resolution, as amended, was approved.<sup>1</sup>**

**Dr Gwenigale resumed the Chair.**

**4. PREPAREDNESS, SURVEILLANCE AND RESPONSE: Item 15 of the Agenda (resumed)**

**Pandemic influenza preparedness: sharing of influenza viruses and access to vaccines and other benefits:** Item 15.2 of the Agenda (Documents A66/17 and A66/17 Add.1)

Dr DAULAIRE (United States of America) noted that collaboration, transparency and rapid response were critical in combating emerging public health threats and reiterated his appreciation of the cooperative and transparent response by the Government of China and others to the avian influenza (H7N9) virus. The Pandemic Influenza Preparedness (PIP) Framework had been reinforced by consultation with civil society stakeholders, including industry. There was potential for synergies between the Framework, the Global Action Plan for Influenza Vaccines and the International Health Regulations (2005), and it was to be hoped that that potential would be realized. His Government encouraged the continued development of an implementation plan for the use of Partnership Contribution resources for both preparedness and response. It would contribute to the United Nations H7N9 Flash Appeal and encouraged other governments to do the same.

Dr AL-TAAE (Iraq) observed that the influenza pandemic of 2009 had been brought under control thanks to international and national coordination and collaboration. His country continued to detect some cases of influenza caused by the pandemic (H1N1) 2009 virus, but had experienced minimal case fatality in the current year. Continued effort was needed in order to upgrade epidemiology and laboratory surveillance and increase accreditation of laboratories at both national and subnational levels. WHO technical support was needed to build capacity for influenza surveillance at sentinel sites.

Dr MAMBOYA (United Republic of Tanzania), speaking on behalf of the Member States of the African Region, welcomed the conclusion of the first Standard Material Transfer Agreement 2 (SMTA 2) with one vaccine manufacturer and the continuing negotiations with four others. Noting the recommendations of the PIP Framework Advisory Group on the allocation of resources from the Partnership Contribution, she said that it was an ethical imperative to ensure equitable and universal

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<sup>1</sup> Transmitted to the Health Assembly in the Committee's fourth report and adopted as resolution WHA66.9.

access to influenza vaccines for both seasonal and pandemic preparedness and response. Viruses must continue to be shared in order to facilitate the development of candidate vaccines, which were important tools when pandemic viruses emerged. Fifteen countries across the Region were using the WHO Shipping Fund Project to share specimens and isolates with WHO collaborating centres; however, reduced funding for that project would mean that fewer countries were able to do so. She called for continued support for the Fund.

Member States in the Region had enhanced their sentinel surveillance systems and laboratory capacity for influenza diagnosis and had continued to detect sporadic cases of pandemic (H1N1) 2009 influenza since the end of the pandemic. Weaknesses remained with regard to skilled personnel, epidemiological and virological surveillance of influenza, and capacity for influenza vaccine production, and the countries of the Region requested continuing support from the Secretariat in those areas.

Ms JACOB (Ireland), speaking on behalf of the European Union and its Member States, as well as Croatia, Turkey, the former Yugoslav Republic of Macedonia, Montenegro, Iceland, Serbia, Albania, Bosnia and Herzegovina, Ukraine, the Republic of Moldova and Georgia, expressed support for the recommendations made by the PIP Framework Advisory Group. The continued timely sharing of PIP materials and related information was important in order to enhance global health security and build capacity to provide high-quality vaccines and diagnostic reagents for all. The current outbreak of avian influenza A(H7N9) could be considered a test case for the application of the Framework. Thus far, the Global Influenza Surveillance and Response System had worked well with regard to the timely sharing of information, virus samples and diagnostic tools.

Welcoming the financial contributions made to the PIP Framework, she agreed that a small share of those contributions should be used to strengthen the Secretariat's capacity to fulfil its duties under the Framework. She urged the Secretariat to conclude additional SMTA 2 negotiations with manufacturers as soon as possible. Partnership Contribution resources should be given to WHO without any attached conditions for use. A clear and transparent plan for their use should be established in order to ensure better pandemic influenza preparedness, in line with the Twelfth General Programme of Work and the Programme budget 2014–2015.

Dr MARTÍNEZ DE CUELLAR (Paraguay) said that her country's National Influenza Centre processed specimens suspected of being influenza or unusual influenza-like viruses and sent specimens or virus isolates to a WHO collaborating centre or reference laboratory for specialized biological analysis. Shipment of specimens and isolates was a significant challenge, particularly when shipping abroad, as there were no companies in the country certified to transport biological materials to WHO collaborating centres, which hindered rapid detection and response. WHO support was needed to enable countries facing such difficulties to work together to overcome them.

Mr COTTERELL (Australia) said that implementation of the PIP Framework was vital to global pandemic preparedness, and should be made a funding priority, including under the Programme budget 2014–2015 and the associated financing dialogue. Additional SMTA 2s should be concluded urgently. In an environment of limited resources, particularly before the first financing dialogue took place, the Director-General should be encouraged to direct up to 10% of the Partnership Contribution funds to the PIP Secretariat, as recommended by the PIP Framework Advisory Group, to be used to support the negotiation of further SMTA 2s. His Government planned to make a one-off contribution of 250 000 Australian dollars in 2013 for that purpose and was considering similar support for the WHO Shipping Fund Project. It would also contribute to the United Nations H7N9 Flash Appeal and would discuss the flexible use of that donation for work on the novel coronavirus.

His country supported a continued focus of attention on strengthening of surveillance and laboratory capacity in developing countries.

Dr YILMAZ (Turkey) said that pandemics threatened all countries, regardless of social, economic or political position, and all countries should therefore contribute to pandemic influenza preparedness. The most important elements of pandemic response, namely vaccines and medicines, must be made available in an equitable manner. The procurement of those items should be carried out under the leadership of WHO.

Professor ARSLAN (Bangladesh), reaffirming his Government's support for various elements of the PIP Framework, emphasized that benefit-sharing under the Framework must ensure that all nations had an equal opportunity to receive influenza vaccines and must consider whether all could equally afford them. Any inequality should be addressed. In the face of the threat of a potential avian influenza A(H7N9) pandemic, an agreement on a virus-sharing mechanism for vaccine development was urgently needed.

Bangladesh had successfully controlled the initial wave of the 2009 pandemic through pharmaceutical and non-pharmaceutical interventions, giving priority to the mitigation of panic. It had improved the capacity and distribution of human resources, established isolation facilities at the district level and below and begun local production of oseltamivir, which could be exported to help other countries to meet their needs. Work aimed at producing vaccines in the country was under way. Bangladesh had developed a modern diagnostic facility for pandemic influenza with biosafety level 3 laboratories capable of performing real-time reverse transcription polymerase chain reaction. His country and other developing countries continued to need financial and technical support in order to strengthen pandemic influenza preparedness.

Dr GWACK Jin (Republic of Korea) thanked WHO for its timely sharing of the pandemic (H1N1) virus in 2009, which had enabled his country to produce vaccines. Global collaboration, including through sharing viruses and facilitating access to vaccines, was essential in order to control pandemic influenza. The PIP Framework and the Global Influenza Surveillance and Response System had thus far functioned efficiently, for which the PIP Framework Advisory Group deserved praise. Also commendable was the collaborative work between WHO and the Government of China to control the avian influenza A(H7N9) virus. That work and all activities under the PIP Framework should continue and be strengthened.

Dr ATTAYA LIMWATTANAYINGYONG (Thailand) welcomed the progress of SMTA 2 negotiations and encouraged the Secretariat to facilitate the speedy conclusion of additional agreements. PIP materials recipients outside the Global Influenza Surveillance and Response System should contribute to the PIP Framework, because they would derive benefit from shared PIP materials. Ensuring the sustainability of the Partnership Contribution mechanism would be a major challenge. The Secretariat should establish and maintain resource-tracking for the Partnership Contribution. Additional national resources should also be mobilized in order to strengthen country surveillance, preparedness and response capacities.

The WHO Global Action Plan for Influenza Vaccines had proved an effective catalyst for stimulating influenza vaccine manufacturing in developing countries; leading to a four-fold increase in production over five years and demonstrating that it was possible to build vaccine manufacturing capacity in developing countries. The Secretariat should continue supporting efforts to strengthen global health security by increasing influenza vaccine supply. Consideration should be given to earmarking part of the Partnership Contribution for that purpose. She noted with concern the slow progress in technology transfers to developing countries, and urged partners to consider accelerating such transfers under SMTA 2s.

Dr IWATA (Japan) said that, in order to ensure smooth implementation of the PIP Framework, the Secretariat should continue working to clarify procedures and arrangements for the rapid sharing of influenza virus specimens, which was a prerequisite for effective international and national responses. When the avian influenza A(H7N9) virus had emerged in China in March 2013, the

Framework had functioned effectively and the Government of China had provided a specimen to a WHO collaborating centre. She thanked the Government of China for its rapid response.

As SMTA 2 negotiations would take time and resources, transitional measures should be put in place for the timely preparation of vaccines in the event of a pandemic. Regarding the revision of pandemic preparedness guidelines mentioned in Annex 1 of document A66/17, given the importance of the guidelines for the formulation of national strategies and policies for pandemic preparedness and response, Member States should be involved in the revision process, which should be transparent.

Ms WØIEN (Norway), acknowledging the progress made in implementing the PIP Framework, including the conclusion of the first SMTA 2 with a major vaccine manufacturer, said that, even though the PIP Framework was functioning satisfactorily, its implementation should be accelerated, particularly in the light of the emergence of the avian influenza A(H7N9) virus. In order to advance the SMTA 2 negotiations in the short term, she could agree to the Advisory Group's recommendation that the PIP Secretariat be authorized to spend a limited part of the annual Partnership Contribution to strengthen its capacity. In the long term, however, in order to ensure sustainable financing for SMTA 2 negotiations, the Director-General should allocate sufficient resources for that purpose and Member States should contribute through the financing dialogue.

**The meeting rose at 12:30.**