## SIXTH MEETING

**Monday, 27 May 2013, at 09:20**

**Chairman:** Mrs K. TYSON (United Kingdom of Great Britain and Northern Ireland)
**later:** Dr P.K. SINGH (India)
**later:** Mrs K. TYSON (United Kingdom of Great Britain and Northern Ireland)
**later:** Dr D. CORRALES DÍAZ (Costa Rica)
**later:** Mrs K. TYSON (United Kingdom of Great Britain and Northern Ireland)

### 1. THIRD REPORT OF COMMITTEE B (Document A66/71)

Mr HAZIM (Morocco), Rapporteur, read out the draft third report of Committee B.

**The report was adopted.**[1]

### 2. HEALTH SYSTEMS: Item 17 of the Agenda (continued)

**Follow-up of the report of the Consultative Expert Working Group on Research and Development: Financing and Coordination:** Item 17.2 of the Agenda (Document A66/23) (continued from the fifth meeting)

The Chairman invited the Committee to consider the draft resolution contained in document A66/23.

**The draft resolution was approved.**[2]

The CHAIRMAN recalled that an informal drafting group had been set up at the Committee's fifth meeting to produce a revised version of the draft decision on follow-up of the report of the Consultative Expert Working Group on Research and Development: Financing and Coordination proposed by the delegation of the United States of America.

Ms MATSOSO (South Africa), speaking in her capacity as chairman of the informal drafting group, thanked Member States and the Secretariat for contributing to its work and urged support for the draft decision. She outlined the salient points of the revised text produced by the informal drafting group, which read:

> The World Health Assembly requested the Director-General, in order to take forward action in relation to monitoring, coordination and financing for health R&D and in line with Resolution A66/23, to convene a technical consultative meeting over 2–3 days in order to assist in the identification of demonstration projects that:

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[1] See page 312.

[2] Transmitted to the Health Assembly in the Committee's fourth report and adopted as resolution WHA66.22.

(1) address identified R&D gaps related to discovery, development and/or delivery, including promising product pipelines, for diseases that disproportionally affect developing countries, particularly the poor, and for which immediate action can be taken;

(2) utilize collaborative approaches, including open-knowledge approaches, for R&D coordination;

(3) promote the de-linkage of the cost of R&D from product price; and

(4) propose and foster financing mechanisms including innovative, sustainable and pooled funding.

The demonstration projects should provide evidence for long term sustainable solutions.

The meeting will be open to all Member States.[1] The Director-General shall invite experts from relevant health R&D fields and experts with experience in managing funds for research and development while safeguarding WHO and public health from undue influence by any form of real, perceived or potential conflicts of interest.

The Director-General shall consult with Regional Directors in accordance with established WHO practice to ensure regional representation and diversity of expertise and experience.

The meeting will be in two parts: firstly a technical discussion among the experts followed by a briefing to and discussion by Member States.

The meeting should be held by the end of 2013. It should be complementary to the Regional consultations referred to in operative paragraphs 2(6) and 4(4) of Resolution A66/23.

A report of the meeting will be prepared and presented by the Director General to the 134th Executive Board.

Dr DAULAIRE (United States of America) said that the draft decision would provide momentum to the draft resolution just approved and bring clarity to forward movement on the activities it covered. The draft resolution represented the best opportunity in decades to increase research and development for diseases primarily affecting developing countries and the world's poor people.

As part of his country's long-standing commitment to research and development for neglected diseases, government agencies were working with other partners to support the development of some 200 of the 365 products currently under examination that would deliver the next generation of life-saving global health products. The United States of America had also invested in almost every type of arrangement that de-linked the price of health products from research and development costs.

At the Sixty-fifth World Health Assembly, his delegation had called for the Director-General to hold consultations with Member States to identify areas of consensus, bearing in mind that intellectual property protections were unlikely to be a major contributor to progress in research and development for neglected diseases affecting poor people. Further, at the PAHO Directing Council in September 2012, the United States of America had reiterated its support for the creation of incentives for research and development mechanisms that de-linked research costs from product prices, and for voluntary financing mechanisms and other measures such as regulatory reform that could serve to eliminate obstacles to innovation. The United States Institute of Medicine's subsequent consultation with biomedical research experts had led to a report highlighting the need for late-stage product development research and noting the importance of setting targets around specific research and development and product needs, rather than financial targets. The outcomes of such actions had led the United States of America to submit the draft decision under consideration.

The most important issue before Member States was how to pay for the long-awaited mechanism to coordinate research for neglected health concerns. The report of the Consultative Expert Working Group had called for a binding global treaty with mandatory contributions from all countries. However, that recommendation had proved contentious, as most of the funding for the new

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

mechanism would need to be provided by countries other than the few that were already investing heavily in that area. Consequently, the demonstration projects would test not only the feasibility of the coordination mechanism but also the willingness of Member States to allocate new funds for the achievement of shared goals. Unless substantial funding for the mechanism was found, Member States would have to scale back their ambitions.

**The draft decision was approved.**[1]

**Universal health coverage:** Item 17.3 of the Agenda (Document A66/24) (continued from the fourth meeting, section 2)

The CHAIRMAN recalled that an informal drafting group had been established at the Committee's third meeting to revise the draft resolution on transforming health workforce education in support of universal health coverage.

Dr VIROJ TANGCHAROENSATHIEN (Thailand), speaking in his capacity as chairman of the informal drafting group, said that during three days of deliberations the group had considered the text proposed by 21 Member States (Bangladesh, Bhutan, China, Democratic People's Republic of Korea, India, Indonesia, Israel, Japan, Malaysia, Maldives, Myanmar, Nepal, Norway, Pakistan, Philippines, South Africa, Sri Lanka, Thailand, Timor-Leste, United States of America, and Viet Nam) at the Committee's third meeting and had reached consensus on a revised version. Three additional Member States, namely France, Senegal, and the United Kingdom of Great Britain and Northern Ireland, had also indicated a wish to sponsor the draft resolution bringing the total number of sponsors to 24. The report on financial and administrative implications for the Secretariat had also been revised. Given the concerted efforts made by the informal working group to reach a consensus, he strongly urged the Committee to approve the amended draft resolution, which read:

The Sixty-sixth World Health Assembly,

**PP1** Recalling resolution WHA59.23 urging Member States to scale up health workforce production in response to the shortages of health workers which hamper the achievement of the internationally agreed health-related development goals, including those contained in the Millennium Declaration;

**PP2** Recognizing that a functioning health system with **an** adequate number **and equitable distribution** of committed and competent health workers at the primary health care level is fundamental to equitable access to health services as an important objective of universal health coverage, and highlighted in the World Health Report 2006;[2]

**PP3** Recognizing also the need to provide adequate, reliable financial and non-financial incentives and an enabling and a safe working environment for the retention of health workers in areas where they are most needed, especially in remote, hard to reach areas and urban slums as recommended by WHO Global Guide**lines**;[3]

**PP4** Recalling resolution WHA64.9 urging Member States to further invest in and strengthen the health delivery systems, in particular primary health care, and adequate human resources for health in order to ensure that all citizens have equitable access to health care and services;

[1] Transmitted to the Health Assembly in the Committee's fourth report and adopted as decision WHA66(12).

[2] The world health report 2006: working together for health. Geneva: World Health Organization; 2006.

[3] Increasing access to health workers in remote and rural areas through improved retention, http://www.who.int/hrh/retention/home/en/index.html.

**PP5** Concerned that in many countries, notably those in sub-Saharan Africa, there is inadequate capacity to train sufficient health workers for adequate coverage of services to the population;

**PP6** Recognizing specific challenges of some Member States which have limited economy of scales in local health workforce education ~~and training~~, their special needs, the potential partnerships and collaborations with other Member States;

**PP6bis Concerned that the health workforce education challenge is global;**

**PP6ter Concerned further that demographic projections highlight that the supply and distribution of the health workforce are issues of concern in the coming decades ~~point towards critical shortages of health workforce in coming decades,~~ irrespective of countries development status;**

**PP7** Recognizing also the needs for intersectoral collaboration among Ministry of Health, Ministry of Education, public and private training institutions, health professional organizations in strengthening health workforce education ~~and training~~ system in producing competent health workforces to support universal health coverage;

**PP8** Concerned also that many countries lack the financial means, facilities and sufficient educators to train adequate, **competent** health workforce; and that there is a need to improve the health workforce education and training system in response to country's health needs;

**PP9** Mindful of the need for **Member States to develop** ~~a~~ comprehensive ~~national~~ polic**ies**~~y~~ and plan**s** on human resources for health, where health workforce education is one of its elements;

**PP10** Recalling resolution WHA63.16 WHO on Global Code of Practice on the International Recruitment of Health Personnel, which urged Member States to create a sustainable health workforce system through effective health planning, education and training and retention strategies;

**PP11** Recognizing the Dhaka Declaration on Strengthening Country Health Workforce in the Countries of South-East Asia Region and the Southeast Asia Regional Committee resolution SEA/RC65/R7 on Strengthening Health Workforce Education and Training in the Region, which urged Member States to assess the health workforce education and training system as a basis for regional strategies to improve health workforce production in response to country's health needs;

**PP12** Recognizing also the recommendations contained in the Global Independent Commission report on "Health professionals for a new century: transforming education to strengthen health systems in an interdependent world";

**PP13** Appreciating the ongoing initiatives to strengthen health workforce education and training in various regions; including **but not limited to** the Medical and Nursing Education Partnership Initiative, in-service training of health workers in sub-Saharan Africa supported by Japan in line with the Toyako G8 Summit commitment and the Asia Pacific Network on Health Professional Education Reform,

1. URGES Member States:[1]

   (1) to further strengthen ~~national health~~ policies, strategies and plans **as appropriate,** through intersectoral policy dialogue among **the relevant ministries that may include** ministries of education, health and finance to ensure that the health workforce education and training contribute to achieving universal health coverage;

   (2) to **consider** conduct**ing** comprehensive assessments of the current situation of health workforce education with the application of, **as appropriate**, standard protocols and tools **once** ~~to be~~ developed by WHO;

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

(3) to **consider** formulat**ing** and implement**ing** evidence-based ~~national~~ policies and strategies, ~~based on findings from~~ **taking into account the findings from** the assessment in the previous paragraph, to strengthen and transform the health workforce education and training, including **but not limited to** ~~through~~ the promotion of inter-professional~~s~~, community-based and health systems-based education, linkages of pre-service education to continuous professional development, and the accreditation system to ensure quality of training institutes and competency of health workforces; with a view to better respond to the health needs of people ~~and the needs of the health systems~~, take**ing** into account the special needs of some Member States which have limited economy of scales in local training;

(4) to provide adequate resources and political support to implement ~~national~~ **policies and** strategies **as appropriate** for the strengthening and transformation of health workforce education;

**(4bis) to share best practices and experiences on health workforce education;**

2. REQUESTS the Director-General ~~and the Regional Directors~~:

(1) to develop a standard protocol and tool for assessment, **which may be adapted to the country contexts;**

(1bis) to support Member States **as appropriate** in conducting comprehensive assessments of the current situation of health workforce education ~~with the application of~~ **using** the protocol ~~which may be adapted to the country contexts~~;

~~(2) **To analyze and synthesize the findings of national assessments to submit recommendations based on that analysis to the sixty-eighth World Health Assembly towards the development of global and regional approaches that may include policies and strategies, to be approved by the sixty-ninth World Health Assembly. approaches.** To convene regional technical consultations to review the findings of country assessments **and consider global and regional approaches, which may include strategies** To support review the findings of country assessments and formulating national strategies to support formulating national strategies regional and global strategies on transforming health workforce education in support of the universal health coverage;~~

**(2bis)** to provide technical support to Member States in **formulating and implementing evidence-based policies and strategies to strengthen and transform their health workforce education;**

~~(3) To provide technical support to Member States in implementing national, regional, and global strategies on transforming health workforce education in support of the universal health coverage;~~

**(3) to consult regionally to review findings of country assessments and produce a report with clear conclusions and recommendations on these findings, which will be submitted to the Sixty-ninth World Health Assembly, through the Executive Board;**

**(4) to develop, based on the report, global and regional approaches, which may include strategies to transform health workforce education and to submit these for consideration by the Seventieth World Health Assembly through the Executive Board.**

~~(4) To submit a progress report on the implementation of this resolution to the sixty-eighth World Health Assembly through the Executive Board.~~

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

**1. Resolution** Transforming health workforce education in support of universal health coverage

**2. Linkage to programme budget 2012–2013 (see document A64/7 http://apps.who.int/gb/ebwha/pdf_files/WHA64/A64_7-en.pdf)**

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|---|---|
| Strategic objective(s): 10 (Category 4 in Programme budget 2014–2015) | Organization-wide expected result(s): 10.9 (Outcome 4.2, Output 4.2.2 for Programme budget 2014–2015) |

**How would this resolution contribute to the achievement of the Organization-wide expected result(s)?**

The resolution relates to activities on integrated people-centred health services under Category 4 of the Twelfth General Programme of Work. For the Programme budget 2014–2015, implementation of the resolution would fall under outcome 4.2 and output 4.2.2: "Countries enabled to plan and implement strategies that are in line with WHO's global strategy on human resources for health and the WHO Global Code of Practice on the International Recruitment of Health Personnel". The resolution covers the period 2013–2017 and activities are included in the approved Programme budget 2014–2015. Implementation of the resolution should lead to an increase in the number of countries that have an investment plan for scaling up and/or improving the training and education of health workers in accordance with national health needs. This will involve an assessment of current practices, and guidance and collaboration to transform education systems in support of a better response to people's health needs.

**Does the Programme budget already include the products or services requested in this resolution? (Yes/no)**

Yes.

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

**(a) Total cost**

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

(i) Five years (covering the period 2013–2017)

(ii) Total: US$ 5.5 million (staff: US$ 3.3 million; activities: US$ 2.2 million)

The relevant programme budgets include US$ 0.6 million for the biennium 2012–2013 and US$ 3.1 million for the biennium 2014–2015. The funding for implementation in the biennium 2014–2015, will come from a combination of assessed and voluntary contributions, generated during the financing dialogue and the follow-up resource mobilization.

**(b) Cost for the biennium 2012–2013**

**Indicate how much of the cost indicated in 3 (a) is for the biennium 2012–2013 (estimated to the nearest US$ 10 000).**

Total: US$ 600 000 (staff: US$ 200 000; activities: US$ 400 000)

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

Headquarters and the six regional offices.

**Is the estimated cost fully included within the approved Programme budget 2012–2013? (Yes/no)**

Yes.

**If "no", indicate how much is not included.**

**(c) Staffing implications**

**Could the resolution be implemented by existing staff? (Yes/no).**

No. Additional staff would be needed at headquarters and in the regional offices to implement the following activities:

- adapting and field testing the assessment tool and guidelines
- providing technical support to Member States
- organizing regional training and monitoring meetings
- developing global and regional approaches, which may include strategies for the transformative education of health professionals.

**If "no", indicate how many additional staff – full-time equivalents – would be required, identifying specific regions and noting the necessary skills profile(s), where relevant.**

One additional full-time equivalent staff member would be required at the global level to adapt tools and develop approaches, and to coordinate and monitor regional activities. In addition, one full-time staff member would be required at the Regional Office for Africa and five 60% full-time equivalent staff members would be required, one in each of the other regional offices, with skills in health professional education and health systems. These staffing needs are for the biennium 2014–2015. During the biennium 2016–2017 the staffing requirement would be halved; it would be evenly distributed across headquarters and the regional offices.

**4. Funding**

**Is the estimated cost for the biennium 2012–2013 indicated in 3 (b) fully funded? (Yes/no)**

No, the current funding available, US$ 100 000, only covers part of the staffing requirements. Funding is needed to review and adapt the current tool, field test it in collaboration with four Member States, and organize two technical consultations (one before and one after the field testing). A technical expert will need to be brought in to support the Secretariat team.

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

US$ 0.5 million; source(s) of funds: external, international donors.

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

**eHealth and health Internet domain names:** Item 17.5 of the Agenda (Documents A66/26 and EB132/2013/REC/1, resolution EB132.R8) (continued from the fifth meeting)

The CHAIRMAN invited the Committee to consider a revised text of the draft resolution on eHealth standardization in interoperability, which reflected the amendments proposed at the fifth meeting by the delegate of France, and which read:

The Sixty-sixth World Health Assembly,

PP1 Recalling resolution WHA58.28 on eHealth;

PP2 Recognizing that information and communication technologies have been incorporated in the Millennium Development Goals;

PP3 Recognizing that the Regional Committee for Africa adopted resolution AFR/RC60/R3 on eHealth in the African Region and that the 51st Directing Council of the Pan American Health Organization adopted resolution CD51.R5 on eHealth and has approved the related Strategy and Plan of Action;[2]

[1] Transmitted to the Health Assembly in the Committee's fourth report and adopted as resolution WHA66.23.

[2] See document CD/51/13.

PP4 Recognizing that the secure, effective and timely transmission of personal data or population data across information systems requires adherence to standards on health data and related technology;

PP5 Recognizing that it is essential to make appropriate use of information and communication technologies in order to improve care, to increase the level of engagement of patients in their own care, as appropriate, to offer quality health services, to support sustainable financing of health care systems, and to promote universal access;

PP6 Recognizing that the lack of a seamless exchange of data within and between health information systems hinders care and leads to fragmentation of health information systems, and that improvement in this is essential to realize the full potential of information and communication technologies in health system strengthening;

PP7 Recognizing that, through standardized electronic data: health workers can gain access to fuller and more accurate information in electronic form on patients at the point of care; pharmacies can receive prescriptions electronically; laboratories can transmit test results electronically; imaging and diagnostic centres have access to high-quality digital images; researchers can carry out clinical trials and analyse data with greater speed and accuracy; public health authorities have access to electronic reports on vital events in a timely manner, and can implement public health measures based on the analysis of health data; and individuals can gain access to their personal medical information, which supports patient empowerment;

PP8 Recognizing that advances in medical health care, coupled with an exponential increase in the use of information and communication technologies in the health sector and other related fields, including environment, have brought about a need to collect, store and process more data about patients and their environment in multiple computer and telecommunication systems;

PP9 Recognizing that the electronic collection, storage, processing and transmission of personal health data require adherence to the highest standards of data protection;

PP10 Recognizing that the electronic transmission of personal or population data using health information systems based on information and communication technologies requires adherence to standards in health data and technology in order to achieve a secure, timely and accurate exchange of data for health decision-making;

PP11 Emphasizing that scientific evaluation of the impact on health care outcomes of health information systems based on information and communication technologies is necessary to justify strong investment in such technologies for health;

PP12 Highlighting the need for national eHealth strategies to be developed and implemented, in order to provide the necessary context for the implementation of health data standards, and in order that countries undertake regular, scientific evaluation;

PP13 Recognizing that it is essential to ensure secure online management of health data, given their sensitive nature, and to increase trust in eHealth tools and health services as a whole;

**PP14 Emphasizing that health-related global top-level domain names in all languages, including "*.health*", should be operated in a way that protects public health, including by preventing the further development of illicit markets of medicines, medical devices and unauthorized health products and services; [France]**

1. URGES Member States:[1]

(1) to consider, as appropriate, options to collaborate with relevant stakeholders, including national authorities, relevant ministries, health care providers, and academic institutions, in order to draw up a road map for implementation of health data standards at national and subnational levels;

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

(2) to consider developing, as appropriate, policies and legislative mechanisms linked to an overall national eHealth strategy, in order to ensure compliance in the adoption of health data standards by the public and private sectors, as appropriate, and the donor community, as well as to ensure the privacy of personal clinical data;

**(3) to consider ways for ministries of health and public health authorities to work with their national representatives on the ICANN Governmental Advisory Committee (GAC) in order to coordinate national positions towards the delegation, governance and operation of health-related global top-level domain names in all languages, including "*.health*", in the interest of public health; [France]**

2. REQUESTS the Director-General, within existing resources:

(1) to provide support to Member States, as appropriate, in order to integrate the application of health data standards and interoperability in their national eHealth strategies through a multistakeholder and multisectoral approach including national authorities, relevant ministries, relevant private sector parties, and academic institutions;

(2) to provide support to Member States, as appropriate, in their promotion of the full implementation of health data standards in all eHealth initiatives;

(3) to provide guidance and technical support, as appropriate, to facilitate the coherent and reproducible evaluation of information and communication technologies in health interventions, including a database of measurable impacts and outcome indicators;

(4) to promote full utilization of the network of WHO collaborating centres for health and medical informatics and eHealth in order to support Member States in related research, development and innovation in these fields;

(5) to promote, in collaboration with relevant international standardization agencies, harmonization of eHealth standards;

**(6) to convey to the appropriate bodies, including the ICANN GAC and ICANN Constituencies, the need for health-related global top-level domain names in all languages, including "*.health*" to be consistent with global public health objectives; [France]**

**(7) to continue working with the appropriate entities, including the ICANN GAC and ICANN Constituencies as well as intergovernmental organizations, towards the protection of the names and acronyms of intergovernmental organizations, including WHO, in the Internet Domain Name System; [France]**

(~~6~~**8**) to report regularly through the Executive Board to the World Health Assembly on progress made in the implementation of this resolution.

Professor AZAD (Bangladesh), accepting the amendments proposed by the delegate of France, proposed that the draft resolution should be amended further: by adding the words "and therefore eHealth standardization and interoperability should address standardization and interoperability issues related to hardware, systems, infrastructure, data and services" at the end of the eighth preambular paragraph; by replacing the words "health data standards", wherever they occurred, with "eHealth and health data standards"; and by amending subparagraph 2(8) to read: "to develop a framework for assessing progress in implementing this resolution and report back through the Executive Board and World Health Assembly using that framework periodically."

Dr DIALLO (Mauritania) supported the amendments proposed by the delegate of France and the proposals just made by the delegate of Bangladesh, which did not substantively change the text; rather, they strengthened it in certain respects.

Ms BLACKWOOD (United States of America), referring to subparagraph 2(8) and noting that the text proposed by the delegate of France contained the words "report regularly to the Executive Board … on progress" whereas the amendment proposed by the delegate of Bangladesh used the

phrase "develop a framework for assessing progress", requested clarification from the Secretariat on the differences between the two proposed reporting methods, particularly in terms of any cost implications.

Dr KIENY (Assistant Director-General) said that the Secretariat had not yet had time to prepare a full costing of the newly proposed framework for assessing progress. Noting that it offered a more structured means of reporting, she considered that the difference in cost should be relatively modest.

Dr DIALLO (Mauritania) said that he considered that the costs would fall within the limits of available resources and were likely to be very modest.

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

**Dr Singh took the Chair.**

**3. PROGRESS REPORTS**: Item 18 of the Agenda (Documents A66/27 and A66/27 Add.1)

The CHAIRMAN pointed out that document A66/27 Add.1 had been prepared to supplement progress report D on strengthening national health emergency and disaster management capacities and the resilience of health systems. She invited the Committee to sequence its consideration of the item in accordance with the grouping reflected in document A66/27, starting with the progress reports under the heading Noncommunicable diseases.

**Noncommunicable diseases**

**A. Strengthening noncommunicable disease policies to promote active ageing (resolution WHA65.3)**
**B. Global strategy to reduce the harmful use of alcohol (resolution WHA63.13)**
**C. Sustaining the elimination of iodine deficiency disorders (resolution WHA60.21)**

Dr DAULAIRE (United States of America), referring to the progress report on strengthening noncommunicable disease policies to promote active ageing, said that, given the demographic transitions that were under way globally, a range of policies and actions were needed to promote health and activity at all ages. Using a life-course approach would ensure that populations entered older age in good health.

In implementing resolution WHA65.3, WHO should ensure that actions were well coordinated and linked to the implementation of the global action plan for the prevention and control of noncommunicable diseases 2013–2020, and that reporting capacity in respect of indicators and targets under the comprehensive global monitoring framework for noncommunicable diseases was strengthened. WHO's efforts to develop a global agenda on long-term care in a range of resource settings, starting with an expert meeting in early 2013, were vital to ensuring the health and well-being of older persons and their families and caregivers. The WHO Global Network of Age-friendly Cities and Communities commendably exemplified efforts to establish healthy habits and ensure that environmental factors contributed to maintaining them throughout the lifespan. He looked forward to the separate world report on ageing and health to be issued in 2015, and hoped that it would deal with the subject of mistreatment of older persons.

[1] Transmitted to the Health Assembly in the Committee's fourth report and adopted as resolution WHA66.24.

Ms ANDERSSON (Sweden), speaking on behalf of the five Nordic countries, Denmark, Finland, Iceland, Norway, and Sweden, said that progress reports were a central component of oversight and evaluation and as such deserved greater attention from Member States. She therefore welcomed the suggestion made by the Director-General at the 132nd session of the Executive Board that both the frequency and the structure of reporting on the results of resolutions should be reviewed. Regardless of the format used for progress reports, they must be linked to the results chain and contribute to the learning process within the Organization. She requested the Secretariat to indicate whether they could also be linked more closely to the regular reporting on implementation of the programme budget in its newly restructured format.

Turning to the global strategy to reduce the harmful use of alcohol, she welcomed Member States' increased commitment in that area. Implementation of the global strategy was crucially important to preventing and reducing the incidence of noncommunicable diseases. At the same time, alcohol was a recognized risk factor for some infectious diseases. Although the global alcohol strategy provided a strong mandate for WHO to strengthen its actions at all levels, it was a matter of concern that the resources available for that work were reported to be inadequate. She therefore welcomed the increase in the allocation for work on noncommunicable diseases in the Programme budget 2014–2015 and urged the Director-General to ensure that the Organization fulfilled its commitment to implementation of the global strategy and its support mechanisms.

Ms SOSIALINE (Indonesia) endorsed the progress report on strengthening noncommunicable disease policies to promote active ageing. Indonesia's elderly population was one of the largest in the world and the Government had been working to synchronize and strengthen its noncommunicable disease and healthy ageing programmes in order to increase life expectancy, for which purpose additional WHO technical support was requested. Standards of primary, secondary and tertiary health care for the elderly were being upgraded, with an emphasis on prevention of noncommunicable diseases, which were the dominant risk for that segment of the population. Other programmes included home care for the elderly and empowerment through the establishment of community groups. Indonesia intended to develop age-friendly cities and communities under its comprehensive and integrated approach to promoting healthy and active ageing.

Dr HARTIGAN-GO (Philippines) expressed appreciation for WHO's efforts to enhance the prevention and control of noncommunicable diseases in older persons and looked forward to the results of the longitudinal studies that would be used to guide evidence-based strategies in that area. The Philippines had initiated a plan of action for senior citizens that was intended to promote better outcomes through focused geriatric health package delivery and the establishment of a responsive and equitable continuum of good-quality care in various settings. Legislative efforts currently centred on two bills, one on long-term care for senior citizens and one on preventing abuse of the elderly.

Ms PATTERSON (Australia) commended WHO's ongoing work on noncommunicable diseases, including the important focus on strengthening noncommunicable disease policies to promote active ageing, the progress in identifying evidence-based strategies for mainstreaming the promotion of healthy ageing, and the drafting of technical guidance for the integrated care of older persons with noncommunicable diseases.

Looking ahead, she supported the aim of drafting a global agenda on long-term care of older persons in developed and less developed settings and the plans for a world report on ageing and health to be issued in 2015. She looked forward to future reporting on those key initiatives in the context of reports to the governing bodies on implementation of the Programme budget 2014–2015.

Ms Chun-Ying HUANG (Chinese Taipei), referring to paragraph 7 of document A66/27, said that Chinese Taipei had promoted WHO's age-friendly cities and communities programme through a central government directive to city leaders. Every city and county had also signed the Dublin Declaration on Age-friendly Cities and Communities. In addition, Chinese Taipei had compiled

recommendations from WHO publications on health care and hospital standards with a view to developing a system of recognition for hospitals providing age-friendly health-care services. Chinese Taipei intended to join the WHO Health Promoting Hospitals Network in order to extend the recognition framework to other countries.

Ms MUGO (Kenya), speaking on behalf of the Member States of the African Region and referring to the global strategy to reduce the harmful use of alcohol, said that alcohol use continued to increase the disease burden in the Region, being responsible for 2.4% of all deaths. Several steps had been taken to halt that trend, including the adoption of a strategy to reduce the harmful use of alcohol in 2010, the establishment of agencies and authorities to coordinate and implement alcohol policies, the development of legislation on alcohol, and the implementation of the African Regional Information System on Alcohol and Health. One third of all countries in the Region had developed alcohol policies.

Despite the achievements to date, challenges remained, including the lack of resources to develop effective policy measures and interventions; weak or non-existent coordination mechanisms; lack of or low public awareness of alcohol-related harm; the focus on alcohol as a source of income rather than on its health-related and social costs; interference from the alcohol industry; pressure against alcohol regulation from economic operators; and inadequate regulation of illicit alcohol production. The African Region had therefore proposed several lines of response to the problem, including regional support for the development of alcohol policies, strategies and legislation; strengthening of a multisectoral approach in policy development and implementation; an emphasis on marketing regulations to limit availability and price regulation through taxation; integration of alcohol interventions in existing health programmes; and new policy options for financing alcohol management activities.

Dr HORI (Japan) said that despite the progress made in implementing resolution WHA65.3 on strengthening noncommunicable disease policies to promote active ageing, there was a lack of scientific evidence on which to base policies and strategies at the global level and especially in resource-limited settings. The results of ongoing WHO research and other activities should be compiled into a solid evidence base so that effective action could be taken.

In Japan several steps had been taken to promote active ageing, including the establishment of a committee to discuss the challenges and needs related to ageing, with a view to subsequently developing technical cooperation projects with other countries.

Dr ABDULRAHIM (Bahrain) expressed appreciation for the Secretariat's efforts to support Member States in elaborating and strengthening national policies, measures and capacity-building with respect to the global strategy to reduce the harmful use of alcohol and for its establishment of the global network of WHO national counterparts for implementation of that strategy. The harmful use of alcohol was a problem that demanded concerted efforts for the development of national strategies and clear plans. Joint national committees should be established, as should voluntary centres for raising awareness, particularly in young people, and 24-hour helplines. Alcohol-related medical problems should be followed up through treatment centres and social research units. Emphasis should also be placed on raising awareness of the need for women to avoid alcohol use during and after pregnancy. Bahrain was committed to implementation of the global strategy.

Ms KARISES (Namibia), speaking on behalf of the Member States of the African Region and referring to the report on strengthening noncommunicable disease policies to promote active ageing, pointed out that 80% of noncommunicable diseases occurred in developing countries and that increased efforts were needed across the African continent to prevent and control such diseases, which constrained socioeconomic and human development. The populations of most African Member States were currently in a stage of epidemiological and demographic transition and the burden of

noncommunicable diseases was rising rapidly. It was essential to undertake more research in order to gain a better understanding of those diseases and assess their impact on older persons.

Resolution WHA65.3 requested the Director-General to provide support to Member States in several areas and placed emphasis on multisectoral approaches to healthy ageing and building better systems of integrated care for older persons. In the context of that support, WHO could commit its country offices to expand the current longitudinal studies being undertaken in several African Member States in order to further improve the knowledge of noncommunicable diseases and ageing in Africa.

She welcomed the fact that the Secretariat was preparing technical advice on various aspects of the prevention and control of noncommunicable diseases in older age, as well as an intervention guide for the assessment, management and support of frail, dependent older people in non-specialized health settings, as outlined in paragraph 5 of document A66/27.

Ms SOSIALINE (Indonesia), referring to the progress report on the global strategy to reduce the harmful use of alcohol, said that, although there was not a high prevalence of alcohol use in Indonesia, in some provinces traditional alcohol production had become a common income-generating and recreational activity. Her Government was therefore implementing various measures in line with the global strategy to reduce the harmful use of alcohol, and requested further WHO technical support in that area.

Turning to the progress report on sustaining the elimination of iodine deficiency disorders, she said that the Government had made various attempts to meet global iodine deficiency disorder targets by imposing salt fortification requirements and establishing an iodine deficiency elimination team. However, progress was being hampered by a number of constraints. Several action plans had been established to improve implementation of the programme, and efforts were continuing to scale up national household coverage and improve the quality of iodized salt.

Dr BUSTREO (Assistant Director-General) thanked Member States for their expressions of support for the progress report on strengthening noncommunicable disease policies to promote active ageing. The promotion of active ageing had been identified as a priority for WHO in the Twelfth General Programme of Work and the Programme budget 2014–2015.

She noted requests for progress reports to be issued in 2014 and confirmed that the Secretariat had already started work on a global report on ageing and health as the basis for future action. The global report would contain the results of the WHO high-level meeting on long-term care and information on health-care system responses to the need to enhance resilience and independence in older persons. The outcome document of the meeting was in the process of being transformed into an agenda for action and would be published shortly. The Secretariat would also include the results of the WHO Study on global ageing and adult health, which would contain information on the health of older persons in low- and middle-income countries including China, Ghana, India, Mexico, the Russian Federation, and South Africa. The global report would be a critical tool for informing global policies and practices on ageing.

The Secretariat was also working with several Member States on a special issue of the *Bulletin of the World Health Organization* on women's health beyond the reproductive years, to be published in September 2013. It would contain data on the epidemiological and demographical transition affecting older women, including information on breast and cervical cancer and cardiovascular diseases, and would focus on how health systems in low- and middle-income countries were responding to the needs of older women.

Dr SAXENA (Mental Health and Substance Abuse) thanked Member States for their expressions of support for the progress report on the global strategy to reduce the harmful use of alcohol. The Secretariat fully recognized the role of harmful use of alcohol as a risk factor not only for noncommunicable diseases but also for other diseases, and its overall impact on health. The work of the Secretariat on the issue was guided by the global strategy to reduce the harmful use of alcohol along with other action plans under consideration by the Health Assembly.

He took note of the concern expressed by the delegate of Sweden that resources for the global alcohol strategy were reported to be inadequate. Responding to the statements by the delegates of Kenya and Bahrain, he said that WHO continued to provide technical support on request and would continue to support the strengthening of global alcohol control measures and policy. The Secretariat recognized Member States' concerns about the actions of the alcohol industry. The Director-General's statement at the Global Alcohol Policy Symposium held in Turkey in April 2013 had set out the example of WHO action in that area. In response to the statement by the delegate of Bahrain, he confirmed that WHO was actively developing evidence-based recommendations on the prevention and management of alcohol use by pregnant women and guidelines would be available by early 2014, as would the next report on alcohol and health.

**Mrs Tyson resumed the Chair.**

Mr HANNIFFY (Ireland), speaking on behalf of the European Union and its Member States, requested that consideration of progress reports D and E in the area of preparedness, surveillance and response be deferred for a short time, in order to ensure that certain delegates, including senior members of national delegations, could be present for the discussion of matters to which the European Union attached particular importance.

In reply to a question from Mr USTINOV (Russian Federation), the CHAIRMAN suggested that the Committee should defer consideration of progress reports D and E to its seventh meeting.

**It was so agreed.**

**Communicable diseases**

**F. Eradication of dracunculiasis (resolution WHA64.16)**
**G. Smallpox eradication: destruction of variola virus stocks (resolution WHA60.1)**

Mr WAYESA (Ethiopia), speaking on behalf of the Member States of the African Region and referring to the progress report on eradication of dracunculiasis, said that although the disease was declining, it remained endemic in Chad, Ethiopia, Mali and South Sudan, with the largest proportion of global cases in 2012 occurring in South Sudan. It was encouraging to note that efforts towards the eradication of the disease were being implemented in a more coordinated manner by countries in which the disease was endemic, but strong cross-border coordination was required to complete the process.

The Member States of the African Region were grateful to WHO, UNICEF, The Carter Center and other local and international partners for their enormous contribution to eradication efforts, and urged the Director-General to continue advocating for increased technical and financial support in order to reach the goal of transmission interruption by 2015.

Dr NICKNAM (Islamic Republic of Iran), referring to the progress report on smallpox eradication: destruction of variola virus stocks, said that, since the report of the fourteenth meeting of the WHO Advisory Committee on Variola Virus Research had been published only recently, his delegation would be able to make detailed comments on its content only at a later date. However, he was concerned that the Advisory Committee continued to approve a wide range of projects using variola virus. That was inconsistent with the global consensus on the destruction of the remaining stocks of live variola virus as well as the Advisory Committee's own scientific conclusions. The scope and number of active variola projects approved by WHO should decrease, reaching zero by 2014 at the latest. The Secretariat should also make arrangements to enable the WHO Advisory Group of Independent Experts to review the smallpox research programme in order to fulfil its mandate in a timely manner.

Dr DAULAIRE (United States of America), recalling the consensus reached at the Sixtieth World Health Assembly on a set of research goals and the establishment of an expert advisory group to inform decision-making on that important matter, said that the WHO Advisory Committee on Variola Virus Research continued to carry out its responsibilities in accordance with its mandate. He pointed out that the consensus had been reiterated in 2011, at which time there had been a call for inclusion of a substantive item on the subject in 2014. The process was designed to ensure that remaining stocks of the virus were held in a safe and secure way, and that research was conducted in accordance with a transparent and multilateral process until such time as proven countermeasures were in place and it was safe to destroy the remaining stocks.

Dr MANAMOLELA (Lesotho), speaking on behalf of the Member States of the African Region, recalled that the debate on when to destroy the remaining virus stocks had been continuing for some years. The Sixty-third World Health Assembly had decided to reaffirm the decision of previous Health Assemblies that the remaining stocks of the virus should be destroyed. It had also reaffirmed the need to reach consensus on a new date for destruction once research outcomes critical to an improved public health response in the event of an outbreak so permitted. Stocks of the smallpox virus still existed in the WHO repositories for which stringent safety measures were in place. However, during the Sixty-third World Health Assembly, it had been noted that the virus also reportedly existed in other locations, that it could potentially be released deliberately to cause harm and that no action had been proposed to put control measures in place.

Following the global eradication of smallpox, diagnosis and treatment skills had been largely lost, and fresh, updated training was required to ensure that the disease could be contained in the unlikely event of an outbreak. Populations over time had also lost immunity to the virus, so that it was imperative to stockpile the vaccine.

The Member States of the African Region had noted great progress in the implementation of resolution WHA60.1 and hoped that information sharing and technology transfer to strengthen laboratory capacity in developing countries would be accelerated. Variola virus stocks in existing WHO repositories should be retained under strict quality assurance systems to allow vital research, production of vaccines and implementation of preparedness measures for a smallpox outbreak to continue until such time as the list of research questions had been exhausted. The matter should be given priority with the aim of eventually destroying all stocks.

Professor HALTON (Australia) said that research into the variola virus was of great importance and should be pursued in a careful, supervised and responsible manner, pending achievement of a level of global trust at which destruction of the virus stocks could be considered. She agreed with the delegate of Lesotho that one of the reasons why closure on the matter, which had been discussed by the Health Assembly on numerous occasions, was elusive was that uncertainty remained as to whether the location of all stocks of the virus had been ascertained.

Dr ATTAYA LIMWATTANAYINGYONG (Thailand) said that the retention of live variola samples for purposes of scientific research to promote a better understanding of pox viruses and the development of new antiviral medicines remained controversial, since it served no clear public health purpose and, furthermore, risked abuse that could cause harm to humans. Her delegation had therefore consistently supported WHO's historic smallpox eradication programme and noted that a decision regarding the destruction of the remaining live variola virus stocks in existence was to be taken at the Sixty-seventh World Health Assembly in 2014. She called on the Secretariat to provide Member States with an update on variola virus research findings, so that an informed decision could be taken at that time. Those countries that conducted research into variola virus should provide intellectual property rights for antiviral medicines and vaccines, particularly for developing countries, and increase funds for the stockpiling of antiviral drugs and smallpox vaccines for WHO. They should also provide technical support to developing countries on national disease surveillance for the prompt detection of smallpox in the event of an incident involving biological weapons.

Dr ENGELS (Control of Neglected Tropical Diseases), speaking in response to comments on the progress report on eradication of dracunculiasis, said that according to provisional data, 44 cases of dracunculiasis had been reported in the current year, up to 19 May 2013, 37 of them in South Sudan, reflecting an 80% decline compared with the number reported by that country for the same period in 2012. He thanked the four countries in which the disease was endemic for their continuing efforts to eradicate dracunculiasis and welcomed the continued surveillance efforts of countries in the pre-certification phase and those that had already been certified as free of dracunculiasis transmission. WHO remained strongly committed to consigning the disease to history.

Dr FUKUDA (Assistant Director-General), responding to comments on the progress report on smallpox eradication: destruction of variola virus stocks, said that, as noted by speakers, the difficult question of destruction of variola virus stocks had been under discussion for some years by the Health Assembly, and that further substantive discussion would take place at the Sixty-seventh World Health Assembly in 2014. In the meantime, both the WHO Advisory Committee on Variola Virus Research and the WHO Advisory Group of Independent Experts to review the smallpox research programme would be meeting in September 2013. He agreed with the delegate of Lesotho that the medical ability to diagnose infections had become weaker, but noted that steps were being taken to establish a network of diagnostic laboratories that could provide quick diagnosis in the event of a new natural occurrence of the virus. The Ad Hoc Committee on Orthopoxvirus Infections would also be convened later in order to review the size of the smallpox vaccine stockpile needed to support an emergency response, and arrangements were being made by the Secretariat to involve the Strategic Advisory Group of Experts on immunization in its discussions.

**Dr Corrales Díaz took the Chair.**

**Health systems**

**H. Patient safety (resolution WHA55.18)**
**I. Drinking-water, sanitation and health (resolution WHA64.24)**
**J. Workers' health: global plan of action (resolution WHA60.26)**
**K. Strategy for integrating gender analysis and actions into the work of WHO (resolution WHA60.25)**
**L. Progress in the rational use of medicines (resolution WHA60.16)**
**M. Health policy and systems research strategy**

Mr BERTONI (Italy), referring to the progress report on workers' health: global plan of action, said that asbestos-related diseases placed a huge burden on society, and that he therefore welcomed the action being taken by the Secretariat towards their elimination, as outlined in its report (document A66/27).

His country had banned the use of asbestos-containing materials in 1992. It had engaged in a complex and challenging asbestos abatement programme, and was drawing up a national plan that would include actions suggested during an interministerial conference in November 2012.

Dr KAMALIAH MOHAMAD NOH (Malaysia), referring to the progress report on patient safety, said that it would have been useful to include in it information on the outcome and impact of the initiatives mentioned, in addition to the number of countries implementing such initiatives. More details about the work of the Patients for Patient Safety network should be provided in the future and it would be interesting to know what feedback had been received from the universities that had used the Patient Safety Curriculum Guide. Malaysia hoped that more initiatives and guidelines would be produced on improving patient safety in primary care.

Dr ALZAYANI (Bahrain) said that more could and should be done in order to improve patient safety in hospitals and primary health care clinics. Political will and administrative efforts were required to reduce the number of accidents and medical errors, and her country would welcome the development of specific diploma courses on patient safety. She urged the Secretariat and Member States to continue their efforts to ensure patient safety.

Ms STIRØ (Norway), speaking on behalf of Denmark, Finland, Iceland, Norway, and Sweden, and referring to the progress report on strategy for integrating gender analysis and actions into the work of WHO, welcomed the important steps taken in that area within WHO. Information on the actual impact of the initiatives would have been useful. She was pleased that WHO was promoting the use of sex-disaggregated data, which was essential in order to obtain a valid picture of inequalities in health between men and women, and boys and girls, and would lead to more informed policy recommendations. All relevant data in WHO reports should be disaggregated by sex. She requested information on the efforts being made, pursuant to resolution WHA60.25, to define indicators and to monitor, and assure accountability for, implementation of the strategy for integrating gender analysis and actions into the work of WHO. Future reports should identify progress in relation to the indicators.

WHO should play an active role in the implementation of the United Nations system-wide action plan on gender equality and women's empowerment, and she looked forward to the corresponding action plan being developed in that regard.

She welcomed the establishment in 2012 by the Director-General of a gender, equity and human rights mainstreaming team and called on the Director-General to ensure the Organization's full commitment to that important work. She also requested the Secretariat to consider developing a common strategy for gender, equity and human rights mainstreaming to replace the current strategy on gender, and to outline the advantages and disadvantages of such a change. Lastly, discussions should be held, as appropriate, at future governing body meetings on the efforts to integrate gender, equity and human rights in the work of WHO.

Ms JAMEEL (Maldives), referring to the progress report on patient safety, expressed appreciation of WHO's leadership and Member States' commitments on the subject of promoting patient safety at health-care institutions. Recalling the relevant provisions of resolution WHA55.18, she said that WHO's Patient Safety Programme had had a major impact in meeting the challenges of unsafe care worldwide, in particular through efforts to improve hand hygiene and implement the WHO Surgical Safety Checklist. In addition, research in patient safety had been given high priority within WHO.

Maldives had implemented a hand hygiene campaign, and the WHO Surgical Safety Checklist was to be introduced in all hospitals within the country. Legislation was being introduced to promote the concept of patient safety. Given the fragmented and dispersed nature of the country's islands and its high level of dependence on expatriate health-care workers, it was extremely difficult and challenging to implement effective sustainable measures, and a trained focal point had been designated to deal with patient safety at the atoll level.

She called for renewed momentum on patient safety at WHO and highlighted the importance of leadership, knowledge, and expertise in that regard. Technical support should be provided to enable resource-scarce countries like Maldives to tailor WHO's guidelines to the local context.

Dr MWANSAMBO (Malawi), speaking on behalf of the Member States of the African Region in relation to the progress report on progress in the rational use of medicines, said that overuse and misuse of medicines was widespread and resulted in wastage of scarce resources and health hazards, and contributed to the emergence of antimicrobial resistance, the spread of communicable diseases and adverse drug reactions. The main challenges for the Region were the emergence of antimicrobial resistance and a lack of resources to implement strategies to promote the rational use of medicines.

Malawi commended the progress made by the Secretariat in implementing resolution WHA60.16. Priority interventions for improving the rational use of medicines should include:

increasing policy-makers' awareness of the negative impact of antimicrobial resistance on public health; strengthening laboratory-based antimicrobial resistance surveillance systems; monitoring the use of medicines in health facilities and communities; strengthening hospital pharmacy committees; building the capacity of health personnel in good prescribing and dispensing practices; and educating consumers on the rational use of medicines. Government commitment and the mobilization of additional financial resources were also necessary, as were appropriate regulations on the rational use of medicines and enforcement mechanisms.

Dr DAHN (Liberia), speaking on behalf of the Member States of the African Region with regard to the progress report on workers' health: global plan of action, noted that most countries in her Region had not yet prepared action plans on workers' health but recognized the need for increased efforts to implement the global plan of action. Workers were often employed in hazardous working environments and professions, were inadequately protected by law and were not necessarily aware of their rights. It was incumbent upon health ministries to promote health in the workplace and encourage small and large enterprises to create a healthy work environment and safe jobs.

The Member States of the African Region appreciated WHO's support for the development of occupational health policy and its efforts to strengthen the capacities of health ministries to take the lead on occupational health within the framework of sustainable development and health equity. They remained committed to ensuring equal protection and safe and healthy working conditions for all workers.

Ms SOSIALINE (Indonesia), referring to the progress report on strategy for integrating gender analysis and actions into the work of WHO, said that her country had already implemented a number of gender-responsive measures, including the introduction of sex-disaggregated data, and gender-responsive budgeting, planning and training at the central and provincial levels. In 2006, it had released a report on the use of human rights as a tool to strengthen laws, policies and standards in the area of maternal and neonatal health. Implementation of the recommendations made in the report had been reviewed in 2011. With regard to gender-based violence and human trafficking, Indonesia had developed guidelines and conducted training for health providers at the national, provincial and district levels. Indonesia engaged actively with development partners on gender-responsive strategies, taking into account national culture and norms. It welcomed WHO's encouragement of integrated gender analysis in the implementation of national health programmes.

With regard to the report on progress in the rational use of medicines, she said that Indonesia was actively involved in promoting and improving the rational use of medicines at the national, regional and global level. Steps taken at the national level included the implementation and regular revision of the national essential medicines list, the development of guidelines for the use of antibiotics, capacity-building, the introduction of community-based approaches, and the introduction of the concept of the rational use of medicines in pharmacy and medical curricula. At the regional level, Indonesia had conducted a second training workshop on the rational use of antimicrobial agents in 2012 under the ASEAN Working Group on Pharmaceutical Development. Additional activities and further coordination with stakeholders were required in order to implement and evaluate interventions to promote the rational use of medicines.

Mr PRIMADI (Indonesia), referring to the progress report on workers' health: global plan of action, said that his country's 2009 law on health provided for occupational health efforts aimed at protecting workers. Modernization, industrialization and globalization increased employment opportunities, but could have an adverse impact on workers' health. Occupational health policy must be evidence-based, people-oriented and supported by intersectoral partnerships. The implementation of occupational health service regulations should be facilitated by appropriate technical guidance, bearing in mind that good occupational health practices enhanced a company's image and served to promote business competition. Occupational health was linked to social and economic conditions; it involved many sectors, and strong and synergistic intersectoral cooperation was therefore required to

ensure occupational health protection for vulnerable groups, such as female, migrant and child workers, and those exposed to hazardous materials. Indonesia appreciated the innovative solutions developed by WHO to deliver care through the existing primary health care system, but considered that more attention should be given to the health gaps between workers in developing countries and those in other countries.

Mr DHALLADOO (Mauritius), speaking on behalf of the Member States of the African Region, welcomed the progress made since the adoption of resolution WHA55.18 in the area covered by the report on patient safety. Although growing importance was attached to patient safety at the regional, national and local levels across the African Region, the service-delivery difficulties faced by some national health care systems were adversely affecting the capacity of hospitals to treat diseases such as HIV/AIDS, tuberculosis and malaria, and noncommunicable diseases that were emerging as a major public health concern in many Member States. In extreme cases, a lack of adequate patient safety was leading to increased morbidity and mortality. However, there were grounds for optimism. Noting that the WHO Surgical Safety Checklist was being applied in over 125 hospitals in 30 countries of the Region, he said that an important landmark in patient safety in Africa was the commitment made by African Ministries of Health at the 58th session of the Regional Committee for Africa in 2008 to the adoption of 12 patient safety action areas. That had triggered a broadening of Secretariat support, leading to the promotion of integrated patient safety interventions and culminating in the creation of the programme on African Partnerships for Patient Safety. Under the programme, a network of hospital-to-hospital partnerships had been established involving 14 African and three European countries, and partnership experiences had been the catalyst for change in national patient safety practices in six countries of the Region. Improved patient safety was a prerequisite for better health-care outcomes and for progress towards the attainment of the Millennium Development Goals, in particular in relation to maternal and child health. The 2012–2015 strategy of the African Partnerships for Patient Safety programme proposed an integrated approach based on the strengthening of partnerships, and was an important tool in that regard.

Mr ADJOUMANI (Côte d'Ivoire), speaking on behalf of the Member States of the African Region in relation to the progress report on strategy for integrating gender analysis and actions into the work of WHO, said that the Region was one of those worst affected by gender inequities. Health objectives could not be achieved by or even after 2015 unless those inequities were redressed, and the countries of the Region were therefore paying greater attention to equity and gender in the planning of interventions, preparation of strategic documents, and distribution of human resources in the area of health.

Gender-based violence was also a matter for concern in the Region. The sociopolitical crises affecting some countries were resulting in increased violence against women and the recruitment of child soldiers, including young girls, and served to exacerbate the problem. The consequences of such violence included HIV/AIDS infection, unwanted pregnancies, dangerous abortions, high rates of maternal mortality, anxiety, isolation, stigmatization, the feminization of poverty and suicide. He therefore called for sustained support to enable countries of the Region to strengthen their health sectors and attain Millennium Development Goals 3 (Promote gender equality and empower women) and 5 (Improve maternal health), and to ensure that victims of abuse received a high level of care that took account of their specific needs.

The African Region urged the Organization to take account of equity, gender and human rights in the ongoing WHO reform process.

Mr RUSH (United Kingdom of Great Britain and Northern Ireland), welcoming the report on the – regrettably limited – progress in the rational use of medicines, recalled that the side event held the previous week by the United Kingdom of Great Britain and Northern Ireland, Sweden and other partners had highlighted the challenges posed by antimicrobial resistance. The Secretariat should provide a short, focused report on the implementation of resolution WHA58.27 on improving the

containment of antimicrobial resistance, for discussion as a substantive agenda item by the Executive Board at its 134th session in January 2014. The report should identify options for further action, and Member States should report to WHO on the progress made in developing national approaches and plans to tackle antimicrobial resistance pursuant to the resolution. The United Kingdom of Great Britain and Northern Ireland remained resolutely committed to making progress in the area of antimicrobial resistance, which was one of the key global health challenges of the twenty-first century.

Mrs HARDING-ROUSE (Trinidad and Tobago), referring to the progress report on patient care, said that her Government was implementing a continuous quality improvement strategy to ensure the delivery of good-quality health care to the population. Over the previous decade the Ministry of Health had collaborated with local and international partners and stakeholders in the development of national standards, protocols and guidelines. In 2007 it had pledged support for the first WHO Global Patient Safety Challenge, Clean care is safer care. It had also implemented a number of patient safety initiatives at public health institutions with oversight and technical support from PAHO.

Trinidad and Tobago was involved in WHO's High 5s project. Pilot tests of the correct site surgery standard operating protocol had been conducted in specific operating theatres and the Ministry of Health was well positioned to pioneer the implementation of one of the WHO standard operating protocols with a view to attaining the goals of the High 5s project at both local and regional level.

Dr KANJANA CHUNTHAI (Thailand), referring to the progress report on patient safety, welcomed the efforts of the Secretariat, in collaboration with the WHO Envoy for Patient Safety, to launch a new five-year strategy on patient safety, and urged WHO to play an active role in maintaining momentum for patient safety: the strategy should be posted on the WHO web site.

The national policy on patient safety introduced in Thailand in 2008 had been implemented by all public and private hospitals. Standards concerning medication safety in hospitals had also been developed. Although a patient safety culture had been established among nurses in many hospitals in Thailand, there was a need to improve the competencies of other health-related cadres in that area. Various associations of health professionals had become involved in patient safety movements in Thailand. The Thai Healthcare Accreditation Institution had launched an annual forum for the sharing of knowledge and experience relating to patient safety. It had also developed innovations in patient safety frameworks to be used by health-care professionals.

Lastly, she pointed out that the strong commitment of leaders in education and a clear budgetary allocation were required in order to enhance patient safety education and research.

Ms CHEDEVILLE-MURRAY (France), referring to the progress report on drinking-water, sanitation and health, said that WHO must continue to play a leading role on those issues, in the context of an integrated approach. France welcomed WHO's active participation in the WHO/UNICEF Joint Monitoring Programme for Water Supply and Sanitation and, in particular, the development of targets and indicators for the post-2015 agenda.

Turning to the progress report on patient safety, she said that France also supported WHO's activities under the Patient Safety Programme.

Ms PALMIER (Canada), referring to the progress report on the strategy for integrating gender analysis and actions into the work of WHO, expressed strong support for the strategy and welcomed the commitment to include gender indicators in performance management and development systems. The Secretariat should provide further information on progress in those areas as the strategy was developed and implemented. Canada supported the establishment of a new Gender, Equity and Human Rights Unit to improve the management of cross-cutting priorities and called for continued efforts to strengthen and give priority to the integration of gender actions across WHO as a new gender, equity and human rights strategy was developed.

Mr MHANGWANE (South Africa) welcomed the progress report on health policy and systems research strategy and highlighted the importance of evidence for policy formulation and strategy development. The WHO document entitled *Strategy on health policy and systems research: changing mindsets* outlined options for action and gave countries the opportunity to redirect investment and identify research trends and priorities. South Africa looked forward to the establishment of relevant WHO partnerships with a view to increasing the capacity of research institutions in developing countries.

Mr USTINOV (Russian Federation), referring to the progress report on workers' health: global plan of action, said that the effect of poor working conditions on the development of occupational diseases and the importance of the development of scientifically based, cost-effective measures to prevent them, should not be underestimated. His country had developed a national policy for the elimination of asbestos-related diseases, and in January 2013 a concept had been approved for the national policy in that area, which was based on many years of experience in monitoring such diseases. Russia had been guided by resolution WHA60.26, which provided for a differentiated approach to regulating different types of asbestos. It would continue to take prophylactic measures in relation to diseases caused by asbestos, on the basis of objective scientific research, and would be prepared to share its findings in that regard.

Professor AZAD (Bangladesh), welcomed the progress report on drinking-water, sanitation and health. Bangladesh had ensured access to improved sources of drinking-water for 80% of its population since 2010. Programmes had been implemented to minimize the burden of waterborne diseases and, with assistance from the Government of Australia's overseas aid programme, efforts were being made to strengthen the water quality programme through the adoption of appropriate policy frameworks and institutional reform in accordance with the WHO Guidelines for drinking-water quality.

A study conducted in Bangladesh had shown that an affordable cholera vaccine could be successfully distributed under the existing national immunization system for all age groups over one year of age. On the basis of Bangladesh's experience, the vaccine had been used in cholera outbreaks in Guinea, Haiti and Thailand to help prevent the spread of the disease.

Despite resource constraints, Bangladesh was working tirelessly to reach the Millennium Development Goal target for water and sanitation by 2015.

Mr MAMACOS (United States of America) expressed support for the suggestion by the delegate of the United Kingdom of Great Britain and Northern Ireland that the agenda of the governing bodies should include antimicrobial resistance in 2014. Member States might also consider establishing a global observatory on antimicrobial resistance that could be linked to the global observatory on research and development for neglected diseases and would provide data to give a better understanding of the scope of the problem and create a basis for future action.

Dr HARTIGAN-GO (Philippines), referring to the progress report on patient safety, said that his country had established legislative and regulatory standards to provide guidance for local implementation of patient safety in various health-care facilities. Continuous research, training and education were conducted in the area of patient safety, and 25 June had been designated national patient safety day for social advocacy purposes. Efforts were also being made to integrate work on patient safety with programmes to prevent antimicrobial resistance through systematic infection control in clinical and animal husbandry settings.

On the subject of progress in the rational use of medicines, he said that, as an active member of the ASEAN Working Group on Pharmaceutical Development, the Philippines was taking the lead in conducting a rapid assessment of the rational use of medicines in all ASEAN Member States in coordination with the Regional Office for the Western Pacific and the ASEAN secretariat. The study would form the basis of ASEAN regional initiatives in support of the rational use of medicines.

The Philippines was also planning to establish a patient reporting system, which would cover pharmacovigilance, vaccine vigilance and suspected substandard/spurious/falsely-labelled/falsified/ counterfeit medical products. The system was expected to be cost efficient, strengthen health regulatory mechanisms and save lives in the clinical setting.

Mr DEANE (Barbados) welcomed the extensive work carried out in the area of patient safety since 2004. However, in view of potential significant legal challenges associated with that work in some countries, approaches other than those outlined in the progress report might be required. The Secretariat should therefore consider providing additional support to Member States for the implementation of continuous quality-improvement mechanisms, in particular with regard to monitoring, evaluation and accreditation systems. He sought guidance from the Secretariat in that regard.

Ms HALÉN (Sweden), speaking on behalf of the Nordic countries, Denmark, Finland, Iceland, Norway and Sweden, on the progress in the rational use of medicines, said that the rapid increase in antimicrobial resistance was placing a heavy disease and economic burden on societies, particularly in the developing countries, where second- and third-line antibiotics were neither accessible nor affordable. Global efforts should be scaled up to tackle the problem. The commitments made in the recently adopted Twelfth General Programme of Work should be translated into increased efforts at all levels of the Organization, and appropriate resources should be allocated to enable WHO and its Antimicrobial Resistance Task Force to meet those commitments. Noting that progress on implementation of resolution WHA58.27, on improving the containment of antimicrobial resistance, had last been reported to the Health Assembly six years previously, she supported the request made by the delegate of the United Kingdom of Great Britain and Northern Ireland. In that connection and in order to facilitate the Executive Board's discussions in January 2014, the regional committees should consider antimicrobial resistance at their meetings in the autumn of 2013.

Lastly, she sought clarification from the Secretariat on a matter raised earlier in the meeting by her delegation, namely how progress reports could be linked more closely to the results chain and the new programme budget structure, and thus be made more useful and relevant.

Mrs CHARLES-STIJNBERG (Suriname), referring to the report on progress in the rational use of medicines, said that in the Caribbean, training and technical support from PAHO had been provided to strengthen the evidence-based selection of medicines. Some countries had completed a review of their essential medicines list, which was updated on a regular basis and focused on generic medicines.

The rational use of medicines was one of the components of the Caribbean pharmaceutical policy developed in 2011, and consideration was being given to a proposal to draw up an essential medicines list for noncommunicable diseases and to update standard treatment guidelines and expand the use of evidence. Some countries of the Caribbean Community, such as Jamaica, had established national health funds that provided medication for a number of noncommunicable diseases. Support had been provided by PAHO for strengthening the regulation of medicines and other technologies. The 17th WHO Model List of Essential Medicines had been adopted for emergency situations to ensure continuity of care and adequate response.

Suriname and Barbados were currently receiving technical support from PAHO to enable them to evaluate and incorporate health technology assessment into their health systems on the basis of the rational use of medicines and associated health products.

Professor HALTON (Australia) endorsed comments made in respect of the progress report on patient safety. Referring to the report on progress in the rational use of medicines, she associated herself with the proposal made by the delegate of the United Kingdom of Great Britain and Northern Ireland in requesting the Secretariat to prepare a report on the implementation of resolution WHA58.27.

Turning to the report on workers' health, she associated herself with the remarks made by the delegate of Italy. Australia strongly supported WHO's global campaign and partnership with ILO to reduce asbestos-related diseases. Noting that IARC considered chrysotile asbestos to be a Group 1 human carcinogen, she said that the lung cancer burden from such asbestos was six times greater than the mesothelioma burden. Broader ratification of the ILO Convention on Safety in the Use of Asbestos, 1986 (No. 162) and the ILO Convention on Occupational Health and Safety, 1981 (No. 155) would help in raising international awareness of the dangers of asbestos and in reducing asbestos-related diseases; Australia encouraged Member States to ratify and implement those instruments. Australia continued to support the inclusion of chrysotile asbestos in Annex III of the Rotterdam Convention on the Prior Informed Consent Procedure for Certain Hazardous Chemicals and Pesticides in International Trade. She welcomed the offer made by the delegate of the Russian Federation to share information, but pointed out that asbestos was a very dangerous product and that the international community had a responsibility to find alternatives and ways to protect workers.

Dr KARAGULOVA (Kazakhstan) said that her country was committed to workers' health and welcomed WHO's efforts in that area. Kazakhstan adhered to a policy for the controlled use of asbestos, in particular chrysotile asbestos, in accordance with the ILO Convention on Safety in the Use of Asbestos, 1986 (No. 162). However, it did not agree with proposals to prohibit the use of all types of asbestos. Regrettably, some countries did not differentiate between the various types of asbestos, and the majority of countries calling for a ban on asbestos were referring to blue rather than chrysotile, or white, asbestos. Her country had accumulated more than 60 years of experience with materials containing chrysotile asbestos and was confident that that type of asbestos differed in all respects from blue asbestos and was less hazardous. The controlled use of chrysotile asbestos in high-density materials could be advantageous, enabling large sections of the population to have access to roofing materials, and clean drinking-water, sewerage and irrigation systems. At the recent sixth meeting of the Conference of the Parties to the Rotterdam Convention, seven countries had objected to the inclusion of chrysotile asbestos in Annex III. However, it should be noted that alternatives to chrysotile asbestos had not yet been researched fully.

Dr ABO DAKA (Iraq), referring to the progress report on strategy for integrating gender analysis and actions into the work of WHO, said that the aim of any health system must be to provide access to good-quality health care, without discrimination. Iraq was cooperating with WHO and various United Nations organizations in efforts focused on gender sensitization and capacity-building, and looked forward to receiving further technical support from WHO for developing appropriate gender-based criteria and principles in order to guarantee equity in the provision of health care.

Dr NISHIKIORI (Japan), referring to the report on progress in the rational use of medicines, said that the rational use of medicines was a prerequisite for patient safety and for maintaining the credibility of health-care systems. Regrettably however, the irrational use of medicines in developed and developing countries was widespread. Japan was particularly concerned about antimicrobial resistance, and called for a comprehensive, system-wide approach to the subject, as well as strong commitment and good coordination among all stakeholders. Japan supported the proposal by the delegate of the United Kingdom of Great Britain and Northern Ireland that antimicrobial resistance should be included as a substantive agenda item for the meetings of the governing bodies in 2014.

Ms VACA GONZALEZ (Colombia), noting that the rational use of medicines was a central pillar of her country's national pharmaceutical policy, highlighted the importance of disseminating the latest independent information on medicines and new treatments, which should be provided using international nonproprietary names. She drew attention to the training in pharmacotherapy that had been taking place in the Region of the Americas, and called for such action to be scaled up and included in policies and initiatives to strengthen and train human resources for health. The progress report failed to mention the important work being done by WHO to develop manuals and tools for the

promotion of critical analysis of pharmaceutical activity. Further encouragement should be given to initiatives of that kind within the framework of resolution WHA60.16, and countries should be given support in the use of such manuals and tools.

She expressed support for the inclusion on the agenda of the next Health Assembly of an item concerning the establishment of a global observatory on antimicrobial resistance. Discussions should take into account national and regional pharmacovigilance systems, which were an important source of information.

**Mrs Tyson resumed the Chair.**

The CHAIRMAN reminded delegates that, as agreed, consideration of progress reports D and E, in the area of preparedeness, surveillance and response, would be taken up at the Committee's next meeting, followed by the continuation of consideration of progress reports H–M.

**The meeting rose at 12:15.**