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WORLD HEALTH ORGANIZATION

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# **SIXTY-SIXTH WORLD HEALTH ASSEMBLY**

**GENEVA, 20–27 MAY 2013**

**SUMMARY RECORDS OF COMMITTEES**

**REPORTS OF COMMITTEES  
LIST OF PARTICIPANTS**

**GENEVA  
2013**

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## ABBREVIATIONS

Abbreviations used in WHO documentation include the following:

ACHR	– Advisory Committee on Health Research	OIE	– <i>Office International des Epizooties</i>
ASEAN	– Association of Southeast Asian Nations	PAHO	– Pan American Health Organization
CEB	– United Nations System Chief Executives Board for Coordination	UNAIDS	– Joint United Nations Programme on HIV/AIDS
CIOMS	– Council for International Organizations of Medical Sciences	UNCTAD	– United Nations Conference on Trade and Development
FAO	– Food and Agriculture Organization of the United Nations	UNDCP	– United Nations International Drug Control Programme
IAEA	– International Atomic Energy Agency	UNDP	– United Nations Development Programme
IARC	– International Agency for Research on Cancer	UNEP	– United Nations Environment Programme
ICAO	– International Civil Aviation Organization	UNESCO	– United Nations Educational, Scientific and Cultural Organization
IFAD	– International Fund for Agricultural Development	UNFPA	– United Nations Population Fund
ILO	– International Labour Organization (Office)	UNHCR	– Office of the United Nations High Commissioner for Refugees
IMF	– International Monetary Fund	UNICEF	– United Nations Children's Fund
IMO	– International Maritime Organization	UNIDO	– United Nations Industrial Development Organization
INCB	– International Narcotics Control Board	UNRWA	– United Nations Relief and Works Agency for Palestine Refugees in the Near East
ITU	– International Telecommunication Union	WFP	– World Food Programme
OECD	– Organisation for Economic Co-operation and Development	WIPO	– World Intellectual Property Organization
		WMO	– World Meteorological Organization
		WTO	– World Trade Organization

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The designations employed and the presentation of the material in this volume do not imply the expression of any opinion whatsoever on the part of the Secretariat of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Where the designation “country or area” appears in the headings of tables, it covers countries, territories, cities or areas.

## **PREFACE**

The Sixty-sixth World Health Assembly was held at the Palais des Nations, Geneva, from 20 to 27 May 2013, in accordance with the decision of the Executive Board at its 131st session.<sup>1</sup>

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<sup>1</sup> Decision EB131(10).



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  - 1.3 Election of the five Vice-Presidents, the Chairmen of the main committees, and establishment of the General Committee
  - 1.4 Adoption of the agenda and allocation of items to the main committees
2. Report of the Executive Board on its 131st and 132nd sessions
3. Address by Dr Margaret Chan, Director-General
4. Invited speaker
5. [Deleted]
6. Executive Board: election
7. Awards
8. Reports of the main committees
9. Closure of the Health Assembly

### **COMMITTEE A**

10. Opening of the Committee<sup>2</sup>
11. WHO reform
12. Programme and budget matters
  - 12.1 Implementation of Programme budget 2012–2013: interim report

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<sup>1</sup> Adopted at the second plenary meeting.

<sup>2</sup> Including election of Vice-Chairmen and the Rapporteur.

- 12.2 Draft twelfth general programme of work
- 12.3 Proposed programme budget 2014–2015
- 21.6 Amendments to the Financial Regulations and Financial Rules
- 13. Noncommunicable diseases
  - 13.1 Draft comprehensive global monitoring framework and targets for the prevention and control of noncommunicable diseases
  - 13.2 Draft action plan for the prevention and control of noncommunicable diseases 2013–2020
  - 13.3 Draft comprehensive mental health action plan 2013–2020
  - 13.4 Draft action plan for the prevention of avoidable blindness and visual impairment 2014–2019
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- 14. Promoting health through the life course
  - 14.1 Monitoring the achievement of the health-related Millennium Development Goals
  - 14.2 Follow-up actions to recommendations of the high-level commissions convened to advance women's and children's health
  - 14.3 Social determinants of health
- 15. Preparedness, surveillance and response
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  - 21.2 Status of collection of assessed contributions, including Member States in arrears in the payment of their contributions to an extent that would justify invoking Article 7 of the Constitution
  - 21.3 Special arrangements for settlement of arrears
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- 23. Staffing matters
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<sup>1</sup> Including election of Vice-Chairmen and the Rapporteur.

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- 24.4 Reassignment of South Sudan from the Eastern Mediterranean Region to the African Region
- 25. Collaboration within the United Nations system and with other intergovernmental organizations
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  - 17.3 Universal health coverage
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  - 17.5 eHealth and health Internet domain names
- 18. Progress reports
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    - B. Global strategy to reduce the harmful use of alcohol (resolution WHA63.13)
    - C. Sustaining the elimination of iodine deficiency disorders (resolution WHA60.21)
  - Preparedness, surveillance and response
    - D. Strengthening national health emergency and disaster management capacities and the resilience of health systems (resolution WHA64.10)
    - E. Climate change and health (resolution EB124.R5)
  - Communicable diseases
    - F. Eradication of dracunculiasis (resolution WHA64.16)
    - G. Smallpox eradication: destruction of variola virus stocks (resolution WHA60.1)
  - Health systems
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- 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

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## LIST OF DOCUMENTS

A66/1 Rev.1	Agenda <sup>1</sup>
A66/2	Report of the Executive Board on its 131st and 132nd sessions
A66/3	Address by Dr Margaret Chan, Director-General, to the Sixty-sixth World Health Assembly
A66/4	WHO reform High-level implementation plan and report
A66/5	Implementation of Programme budget 2012–2013: interim report
A66/6	Draft twelfth general programme of work
A66/6 Add.1	Draft resolution Twelfth General Programme of Work, 2014–2019
A66/7	Proposed programme budget 2014–2015
A66/7 Add.1	Draft resolution Programme budget 2014–2015
A66/8	Draft comprehensive global monitoring framework and targets for the prevention and control of noncommunicable diseases Formal Meeting of Member States to conclude the work on the comprehensive global monitoring framework, including indicators, and a set of voluntary global targets for the prevention and control of noncommunicable diseases
A66/8 Add.1	Report on financial and administrative implications for the Secretariat of resolutions proposed for adoption by the Executive Board or Health Assembly <sup>2</sup>
A66/9 and A66/9 Corr.1	Draft action plan for the prevention and control of noncommunicable diseases 2013–2020 <sup>3</sup>
A66/10 Rev.1	Draft comprehensive mental health action plan 2013–2020 <sup>4</sup>

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

<sup>2</sup> See document WHA66/2013/REC/1, Annex 6.

<sup>3</sup> See document WHA66/2013/REC/1, Annex 4.

<sup>4</sup> See document WHA66/2013/REC/1, Annex 3.

A66/10 Rev.1 Add.1	Report on financial and administrative implications for the Secretariat of resolutions proposed for adoption by the Executive Board or Health Assembly <sup>1</sup>
A66/11	Draft action plan for the prevention of avoidable blindness and visual impairment 2014–2019 Towards universal eye health: a global action plan 2014–2019 <sup>2</sup>
A66/11 Add.1	Report on financial and administrative implications for the Secretariat of resolutions proposed for adoption by the Executive Board or Health Assembly <sup>1</sup>
A66/12	Disability
A66/13	Monitoring the achievement of the health-related Millennium Development Goals
A66/14	Follow-up actions to recommendations of the high-level commissions convened to advance women's and children's health
A66/15	Social determinants of health
A66/16 and A66/16 Add.1	Implementation of the International Health Regulations (2005)
A66/17	Pandemic influenza preparedness: sharing of influenza viruses and access to vaccines and other benefits Pandemic Influenza Preparedness Framework 2013 biennial report
A66/17 Add.1	Pandemic influenza preparedness: sharing of influenza viruses and access to vaccines and other benefits Report of the meeting of the Pandemic Influenza Preparedness Framework Advisory Group
A66/18	Poliomyelitis: intensification of the global eradication initiative
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A66/21	Malaria
A66/22	Substandard/spurious/falsely-labelled/falsified/counterfeit medical products

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<sup>1</sup> See document WHA66/2013/REC/1, Annex 6.

<sup>2</sup> See document WHA66/2013/REC/1, Annex 2.

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A66/23	Follow-up of the report of the Consultative Expert Working Group on Research and Development: Financing and Coordination
A66/24	Universal health coverage
A66/25	The health workforce: advances in responding to shortages and migration, and in preparing for emerging needs
A66/26	eHealth and health Internet domain names
A66/27 and A66/27 Add.1	Progress reports
A66/28	Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan
A66/29	Financial Report and Audited Financial Statements for the year ended 31 December 2012
A66/29 Add.1	Annex: voluntary contributions by fund and by contributor for the year ended 31 December 2012
A66/30	Status of collection of assessed contributions, including Member States in arrears in the payment of their contributions to an extent that would justify invoking Article 7 of the Constitution
A66/31	Scale of assessments for 2014–2015
A66/32	Scale of assessments for 2014–2015 Foreign exchange risk management <sup>1</sup>
A66/33	Amendments to the Financial Regulations and Financial Rules <sup>1</sup>
A66/34	Report of the External Auditor
A66/35	Report of the Internal Auditor
A66/36	Human resources: annual report
A66/37	Report of the International Civil Service Commission
A66/38	Amendments to the Staff Regulations and Staff Rules
A66/39	Report of the United Nations Joint Staff Pension Board
A66/40	Appointment of representatives to the WHO Staff Pension Committee

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<sup>1</sup> See document WHA66/2013/REC/1, Annex 1.

A66/41	Follow-up of the report of the Working Group on the Election of the Director-General of the World Health Organization
A66/42	Real estate
A66/43	Reassignment of South Sudan from the Eastern Mediterranean Region to the African Region
A66/43 Add.1	Report on financial and administrative implications for the Secretariat of resolutions proposed for adoption by the Executive Board or Health Assembly <sup>1</sup>
A66/44	Collaboration within the United Nations system and with other intergovernmental organizations
A66/45	Special arrangements for settlement of arrears: Tajikistan
A66/46	Agreements with intergovernmental organizations Agreement between the World Health Organization and the South Centre <sup>2</sup>
A66/47	Health in the post-2015 development agenda
A66/48	WHO reform Financing of WHO
A66/49	WHO reform High-level implementation plan and report Report of the Programme, Budget and Administration Committee of the Executive Board to the Sixty-sixth World Health Assembly
A66/50	WHO reform Financing of WHO Report of the Programme, Budget and Administration Committee of the Executive Board to the Sixty-sixth World Health Assembly
A66/51	Implementation of Programme budget 2012–2013: interim report Report of the Programme, Budget and Administration Committee of the Executive Board to the Sixty-sixth World Health Assembly
A66/52 and A66/52 Corr.1	Draft twelfth general programme of work Report of the Programme, Budget and Administration Committee of the Executive Board to the Sixty-sixth World Health Assembly

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<sup>1</sup> See document WHA66/2013/REC/1, Annex 6.

<sup>2</sup> See document WHA66/2013/REC/1, Annex 5.

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A66/53	Proposed programme budget 2014–2015 Report of the Programme, Budget and Administration Committee of the Executive Board to the Sixty-sixth World Health Assembly
A66/54	Financial report and audited financial statements for the period 1 January 2012–31 December 2012 Report of the Programme, Budget and Administration Committee of the Executive Board to the Sixty-sixth World Health Assembly
A66/55	Status of collection of assessed contributions, including Member States in arrears in the payment of their contributions to an extent that would justify invoking Article 7 of the Constitution and special arrangements for settlement of arrears: Tajikistan Report of the Programme, Budget and Administration Committee of the Executive Board to the Sixty-sixth World Health Assembly
A66/56	Scale of assessments for 2014–2015 Foreign exchange risk management Report of the Programme, Budget and Administration Committee of the Executive Board to the Sixty-sixth World Health Assembly
A66/57	Amendments to the Financial Regulations and Financial Rules Report of the Programme, Budget and Administration Committee of the Executive Board to the Sixty-sixth World Health Assembly
A66/58	Report of the External Auditor Report of the Programme, Budget and Administration Committee of the Executive Board to the Sixty-sixth World Health Assembly
A66/59	Report of the Internal Auditor Report of the Programme, Budget and Administration Committee of the Executive Board to the Sixty-sixth World Health Assembly
A66/60	Human resources: annual report Report of the Programme, Budget and Administration Committee of the Executive Board to the Sixty-sixth World Health Assembly
A66/61	Report of the International Civil Service Commission Report of the Programme, Budget and Administration Committee of the Executive Board to the Sixty-sixth World Health Assembly
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A66/63	First report of Committee A
A66/64	Committee on Credentials First report

A66/65	Second report of Committee A
A66/66	First report of Committee B
A66/67	Election of Members entitled to designate a person to serve on the Executive Board
A66/68	Second report of Committee B
A66/69	Third report of Committee A
A66/70	Fourth report of Committee A
A66/71	Third report of Committee B
A66/72	Fourth report of Committee B
A66/73	Fifth report of Committee A

#### **Information documents**

A66/INF./1	Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan (report by the Ministry of Health, State of Palestine)
A66/INF./2	Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan (report by the Ministry of Health, Syrian Arab Republic)
A66/INF./3	Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan (report by the Director of Health, UNRWA, for the year 2012)
A66/INF./4	Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan (statement by the Government of Israel)

#### **Diverse documents**

A66/DIV./1 Rev.1	List of delegates and other participants
A66/DIV./2	Guide for delegates to the World Health Assembly
A66/DIV./3	Decisions and list of resolutions
A66/DIV./4	List of documents
A66/DIV./5	Address by Her Excellency Dr Nkosazana Dlamini Zuma, Chairperson of the African Union Commission, to the Sixty-sixth World Health Assembly

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|------------|---|
| A66/DIV./6 | Address by Ms Gunilla Carlsson, Minister for International Development Cooperation, Sweden to the Sixty-sixth World Health Assembly |
| A66/DIV./7 | Address by Dr Jim Yong Kim, World Bank Group President, to the Sixty-sixth World Health Assembly                                    |
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## OFFICERS OF THE HEALTH ASSEMBLY AND MEMBERSHIP OF ITS COMMITTEES

### **President**

Dr Shigeru OMI (Japan)

### **Vice-Presidents**

Dr José V. DIAS VAN-DÚNEM (Angola)

Dr Ahmed bin Mohamed bin Obaid AL  
SAIDI (Oman)

Mr Vidyadhar MALLIK (Nepal)

Professor Raisa BOGATYRYOVA (Ukraine)

Dr Florence DUPerval GUILLAUME  
(Haiti)

### **Secretary**

Dr Margaret CHAN, Director-General

### **Committee on Credentials**

The Committee on Credentials was composed of delegates of the following Member States: Afghanistan, Canada, Cook Islands, Malawi, Mali, Mongolia, Nicaragua, Republic of Moldova, Romania, Sri Lanka, Turkey, and Uganda

**Chairman:** Dr R. WIMAL JAYANTHA  
(Sri Lanka)

**Vice-Chairman:** Ms Roxana ROTOCOL  
(Romania)

**Secretary:** Ms Joanne McKEOUGH (Principal  
Legal Officer)

### **General Committee**

The General Committee was composed of the President and Vice-Presidents of the Health Assembly and the Chairmen of the main committees, together with delegates of the following Member States: Chile, China, Cuba,

Fiji, France, Honduras, Iraq, Ireland, Kazakhstan, Namibia, Russian Federation, Rwanda, Sao Tome and Principe, South Africa, Thailand, United States of America, and Yemen

**Chairman:** Dr Shigeru OMI (Japan)

**Secretary:** Dr Margaret CHAN, Director-General

### **MAIN COMMITTEES**

Under Rule 35 of the Rules of Procedure of the World Health Assembly, each delegation was entitled to be represented on each main committee by one of its members.

### **Committee A**

**Chairman:** Dr Walter T. GWENIGALE  
(Liberia)

**Vice-Chairmen:** Dr Lester G. ROSS (Solomon  
Islands) and Dr Sania NISHTAR (Pakistan)

**Rapporteur:** Dr Victor CUBA ORÉ (Peru)

**Secretary:** Dr Timothy ARMSTRONG,  
Coordinator, Surveillance and Population-  
based Prevention

### **Committee B**

**Chairman:** Mrs Kathryn TYSON (United  
Kingdom of Great Britain and Northern  
Ireland)

**Vice-Chairmen:** Dr Daisy CORRALES DÍAZ  
(Costa Rica) and Dr Poonam Khetrpal  
SINGH (India)

**Rapporteur:** Mr Jilali HAZIM (Morocco)

**Secretary:** Dr Clive ONDARI, Coordinator,  
Medicines Access and Rational Use

## REPRESENTATIVES OF THE EXECUTIVE BOARD

Dr Joy ST. JOHN (Barbados)

Dr REN Minghui (China)

Dr Ahmed Jamsheed MOHAMED (Maldives)



## **PART I**

# **SUMMARY RECORDS OF MEETINGS OF COMMITTEES**



# **GENERAL COMMITTEE**

## **FIRST MEETING**

**Monday, 20 May 2013, at 10:25**

**Chairman:** Dr S. OMI (Japan)  
President of the World Health Assembly

### **1. ADOPTION OF THE AGENDA: Item 1.4 of the Agenda (Document A66/1)**

The CHAIRMAN reminded the Committee that, under its terms of reference as defined in Rule 31 of the Rules of Procedure of the World Health Assembly, its first task was to consider the adoption of the agenda. In the absence of any objection, he took it that the Committee wished to recommend the deletion of one item included on the provisional agenda prepared by the Executive Board (document A66/1): item 5, Admission of new Members and Associate Members, as no new applications had been received.

**It was so agreed.**

The CHAIRMAN further took it that the Committee wished to recommend the adoption of the agenda, as so amended.

**It was so agreed.**

### **2. ALLOCATION OF AGENDA ITEMS TO THE MAIN COMMITTEES AND PROGRAMME OF WORK OF THE HEALTH ASSEMBLY: Item 1.4 of the Agenda (Documents A66/1 and A66/GC/1)**

The CHAIRMAN said that the General Committee's recommendation on the adoption of the agenda would be transmitted to the Health Assembly at its second plenary meeting.

The provisional agenda of the Health Assembly had been prepared by the Executive Board with the proposed allocation of agenda items between Committees A and B on the basis of the terms of reference of the main Committees. It was further proposed that agenda item 21.6, Amendments to the Financial Regulations and Financial Rules should be moved from Committee B to Committee A, for consideration with item 12.3, Proposed programme budget 2014–2015. He took it that the Committee wished to accept that proposal and the allocation of agenda items to the Committees, on the basis of the provisional agenda as amended by the General Committee.

**It was so agreed.**

The DIRECTOR-GENERAL referred to the grave humanitarian situation in the Syrian Arab Republic and to requests received from many Member States to discuss the disruption to that country's health system and the burden placed on those of neighbouring countries as a result of large influxes of refugees. She acknowledged also the strongly held view that the Health Assembly should refrain from

discussing the political aspects of those events and maintain its focus on health in accordance with the Organization's mandate. In order to accommodate those views she proposed that an addendum should be published to document A66/27 covering the humanitarian emergencies in the Syrian Arab Republic, Mali and Central African Republic for consideration as part of the relevant progress report D under agenda item 18: Strengthening national health emergency and disease management capacities and the resilience of health systems (resolution WHA64.10).

The delegates of ANGOLA and NAMIBIA supported that proposal.

The CHAIRMAN took it that the Committee accepted the proposal by the Director-General.

**It was so agreed.**

The CHAIRMAN said that, given the heavy agenda, it would be advisable for the Committee to keep the progress of work under careful review. Arrangements had been made to allow the plenary meetings on Monday and Tuesday to continue until 18:00 if necessary with a view to completing the general debate by Wednesday morning: that would in turn allow Committee B to begin its work on Wednesday afternoon. He asked whether the Committee could agree with those arrangements and with the preliminary daily timetable as amended.

**It was so agreed.**

**The General Committee then drew up the programme of work for the Health Assembly until Wednesday, 22 May.**

The CHAIRMAN drew attention to decision EB132(17), whereby the Executive Board had decided that the Sixty-sixth World Health Assembly should close no later than Tuesday, 28 May 2013.

Dr GWENIGALE (Liberia), Chairman of Committee A, asked why the Health Assembly was not due to close until Tuesday, 28 May, as he believed it would be more efficient, and preferable, for it to finish its work by the weekend.

Everything that was to be discussed at the Health Assembly had already been discussed by the Executive Board, and thus by representatives of all regions, meaning that no item should be subject to further lengthy discussions in the coming days.

The DIRECTOR-GENERAL, welcoming his desire for efficiency, explained to the Chairman of Committee A that, as it was a year in which a proposed programme budget was being discussed, the Health Assembly was following its usual custom of extending the meeting by two days to ensure that it had adequate time to complete its work.

She noted that the matter of WHO reform also covered the governing bodies and the way they worked; it was for Member States to decide how quickly or otherwise they wished to work. The Health Assembly could certainly close early if delegates finished their deliberations sooner than anticipated.

The delegate of FRANCE said that it would not be beneficial to constrain discussions on any item by limiting the number of speakers; delegates should agree, however, to be more disciplined in their work and to improve efficiency by adhering to a strict time limit on the length of interventions.

In the absence of any objection, the CHAIRMAN took it that the proposal to close the Health Assembly no later than Tuesday, 28 May was acceptable.

**It was so agreed.**

The CHAIRMAN, referring to the list of speakers for the debate on item 3 of the Agenda, proposed that, as on previous occasions, the order of the list of speakers should be strictly adhered to and that further inscriptions should be taken in the order in which they were made. Those inscriptions should be handed to the Office of the Assistant to the Secretary of the Health Assembly, or during the plenary to the officer responsible for the list of speakers, on the rostrum. He further proposed that the list of speakers be closed the following day at 10:00. In the absence of any objection, he would inform the Health Assembly of those arrangements at its second plenary meeting.

**It was so agreed.**

**The meeting rose at 10:50.**

## **SECOND MEETING**

**Wednesday, 22 May 2013, at 17:35**

**Chairman:** Dr S. OMI (Japan)  
President of the World Health Assembly

### **1. PROPOSALS FOR THE ELECTION OF MEMBERS ENTITLED TO DESIGNATE A PERSON TO SERVE ON THE EXECUTIVE BOARD (Document A66/GC/2)**

The CHAIRMAN reminded Members that the procedure for drawing up the list of proposed names to be transmitted by the General Committee to the Health Assembly for the annual election of Members entitled to designate a person to serve on the Executive Board was governed by Article 24 of the Constitution and Rule 100 of the Rules of Procedure of the World Health Assembly. In accordance with those provisions, the Committee needed to nominate 12 new Member States for that purpose.

To help the General Committee in its task, two documents were before it. The first indicated the present composition of the Executive Board by region, on which list were underlined the names of the 12 Members whose term of office would expire at the end of the Sixty-sixth World Health Assembly and which had to be replaced. The second (document A66/GC/2) contained a list, by region, of the 12 Members that it was suggested should be entitled to designate a person to serve on the Executive Board. Vacancies, by region, were: Africa, 2; the Americas, 3; South-East Asia, 1; Europe, 2; the Eastern Mediterranean, 2; and the Western Pacific, 2.

As no additional suggestion had been made by the General Committee, the CHAIRMAN noted that the number of candidates was the same as the number of vacant seats on the Executive Board. He therefore presumed that the General Committee wished, as was allowed under Rule 78 of the Rules of Procedure, to proceed without taking a vote since the list apparently met with its approval.

There being no objection, he concluded that it was the Committee's decision, in accordance with Rule 100 of the Rules of Procedure, to transmit a list comprising the names of the following 12 Members to the Health Assembly for the annual election of Members entitled to designate a person to serve on the Executive Board: Albania, Andorra, Argentina, Brazil, Democratic People's Republic of Korea, Egypt, Japan, Namibia, Republic of Korea, Saudi Arabia, South Africa and Suriname.

**It was so agreed.**

### **2. ALLOCATION OF WORK TO THE MAIN COMMITTEES AND PROGRAMME OF WORK OF THE HEALTH ASSEMBLY**

Dr GWENIGALE (Liberia), Chairman of Committee A, and Mrs TYSON (United Kingdom of Great Britain and Northern Ireland), Chairman of Committee B, reported on the progress of the work of their respective committees.



The CHAIRMAN proposed a programme of work for Thursday, 23 May; for Friday, 24 May; and for Saturday, 25 May. He further proposed to review progress of work with the chairmen of the committees and to revise the programme accordingly, if necessary.

**It was so agreed.**

**The meeting rose at 17:40.**

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## **COMMITTEE A**

### **FIRST MEETING**

**Monday, 20 May 2013, at 15:35**

**Chairman:** Dr W.T. GWENIGALE (Liberia)

#### **1. OPENING OF THE COMMITTEE:** Item 10 of the Agenda

The CHAIRMAN welcomed participants and introduced the representatives of the Executive Board, Dr Joy St. John (Barbados), Dr Ren Minghui (China), Dr Jamsheed Mohamed (Maldives) and Mr Pascal Strupler (Switzerland),<sup>1</sup> who would report on the Board's consideration of the relevant items of the agenda. Accordingly, any views they expressed would be those of the Board, not of their respective governments.

#### **Election of Vice-Chairmen and Rapporteur**

The CHAIRMAN informed the Committee that Dr Lester Ross (Solomon Islands) and Dr Sania Nishtar (Pakistan) had been nominated as Vice-Chairmen and Dr Victor Cuba Oré (Peru) as Rapporteur.

**Decision:** Committee A elected Dr Lester Ross (Solomon Islands) and Dr Sania Nishtar (Pakistan) as Vice-Chairmen and Dr Victor Cuba Oré (Peru) as Rapporteur.<sup>2</sup>

#### **2. ORGANIZATION OF WORK**

The CHAIRMAN said that, in view of the full agenda, delegates should limit their statements to three minutes. As at previous sessions, the traffic light system would be used to enforce that limit. If a delegate spoke on behalf of a group of countries, delegates from other countries within that group should limit the length of their statements.

**It was so agreed.**

Ms HAGERTY (Ireland), speaking on behalf of the Member States of the European Union, recalled that, following an agreement between WHO and the European Commission in 2000, the European Union had participated in the World Health Assembly as an observer. She requested that it should also be invited to participate as an observer, without vote, in meetings of subcommittees and other subdivisions of the Health Assembly dealing with matters within the competence of the European Union.

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<sup>1</sup> Participating by virtue of Rules 42 and 43 of the Rules of Procedure of the World Health Assembly.

<sup>2</sup> Decision WHA66(5).

**It was so agreed.**

**3. NONCOMMUNICABLE DISEASES:** Item 13 of the Agenda

**Draft comprehensive global monitoring framework and targets for the prevention and control of noncommunicable diseases:** Item 13.1 of the Agenda (Documents A66/8 and A66/8 Add.1)

**Draft action plan for the prevention and control of noncommunicable diseases 2013–2020:** Item 13.2 of the Agenda (Documents A66/9 and A66/9 Corr. 1)

The CHAIRMAN proposed that subitem 13.1 on a draft comprehensive global monitoring framework and targets for the prevention and control of noncommunicable diseases and subitem 13.2 on a draft action plan for the prevention and control of noncommunicable diseases 2013–2020 should be considered together as they were closely associated.

**It was so agreed.**

Dr ST. JOHN (Barbados, representative of the Executive Board), referring to subitem 13.1, said that the Board, at its 132nd session, had decided to forward the report contained in document A66/8 to the Sixty-sixth World Health Assembly for adoption. She recalled the strong recommendation made at the formal meeting of Member States in November 2012 that the Health Assembly should consider adopting the global monitoring framework for noncommunicable diseases, including 25 indicators and a set of nine voluntary global targets, without reopening discussion on them. Turning to subitem 13.2, she recalled that the Board had considered a previous draft version of the global action plan for the prevention and control of noncommunicable diseases, taking into account that countries were at different stages of development and therefore had different priorities. Some Board members had called for greater flexibility in the draft action plan and others had argued for more prescriptive actions geared to achieving the nine voluntary targets. The Board had therefore decided to agree to a further round of informal consultations in March 2013 with a view to preparing a final draft action plan for consideration by the Sixty-sixth World Health Assembly.

The CHAIRMAN noted that in response to the Board's request the Secretariat had convened a round of informal consultations in March 2013, following which document A66/9 had been produced. The round of informal consultations had included an informal consultation for Member States and organizations of the United Nations system on the development of the action plan, which had taken place from 11 to 13 March in Geneva. He invited one of the co-chairs of the informal consultation to provide an update on the outcome of the discussions.

Mr McIFF (United States of America), in response, said that participants in the informal consultation had reviewed a revised draft action plan and had benefited from the views of a number of nongovernmental organizations and selected private-sector entities. They had commended the improvements made to the draft action plan, including a new Appendix 3 on policy options and cost-effective interventions. The discussions had also covered WHO's leadership and coordination role in relation to the work of other United Nations organizations on noncommunicable diseases, and ways of establishing a United Nations Task Force on Noncommunicable Diseases to support implementation of the action plan. The Secretariat had proposed establishing a global coordination mechanism for noncommunicable diseases. Most participants in the informal consultation had felt that the scope and purpose, as well as the terms of reference, of such a mechanism should be developed with the full participation of Member States through a separate intergovernmental process which could

take place between June and November 2013, after the action plan had been endorsed by the Sixty-sixth World Health Assembly.

Member States had also discussed the reporting cycles to the governing bodies on the progress made in implementing the action plan and achieving the nine voluntary global targets. Discussions had focused on the progress reports on implementation of the actions recommended in the action plan. Several Member States wished the Secretariat to prepare a small set of process indicators to enrich the content of the progress reports before their submission to the Health Assembly. Such indicators would enable the Secretariat to report on progress made by Member States in relation to the policy options under the action plan. They could be designed by the Secretariat, with the full collaboration of Member States, in the context of a separate intergovernmental exercise that could also take place between June and November 2013.

A series of informal hearings, attended by more than 30 Member States, had taken place between 7 and 15 May 2013 in order to facilitate finalization of the draft action plan. The outcomes of the hearings had been made available as a non-paper in all official languages. Participants had focused on the global action plan contained in the Annex to document A66/9 as the basis of further work, before turning to the draft resolution in the same document.

Should Committee A decide to establish a drafting group, it might wish to consider taking a similar approach. He drew attention to a draft resolution on follow-up to the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases, which was proposed by 15 delegations, including his own. The text of the draft resolution read:

The Sixty-sixth World Health Assembly,

PP1 Having considered the reports on A66/8 and A66/9 to the Sixty-sixth World Health Assembly on noncommunicable diseases;

PP2 Recalling the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases,<sup>1</sup> which acknowledges that the global burden and threat of noncommunicable diseases constitutes one of the major challenges for development in the twenty-first century and recognizes the primary role and responsibility of Governments in responding to the challenges of noncommunicable diseases and which also requests the development of a comprehensive global monitoring framework, including a set of indicators, calls for recommendations on a set of voluntary global targets, and requests options for strengthening and facilitating multisectoral action for the prevention and control of noncommunicable diseases through effective partnership; [A/RES/66/2, PP1, PP3, OP61, 62, 64]

PP3 Welcoming the outcome document of the United Nations Conference on Sustainable Development (Rio de Janeiro, 20–22 June 2012), entitled “The future we want” (resolution A/RES/66/288), which commits to strengthen health systems towards the provision of equitable, universal health coverage and promote affordable access to prevention, treatment, care and support related to noncommunicable diseases, especially cancer, cardiovascular diseases, chronic respiratory diseases and diabetes, and commits to establish or strengthen multisectoral national policies for the prevention and control of noncommunicable diseases; [A/RES/66/288, OP141]

PP4 Acknowledging the Moscow Declaration adopted by the First Global Ministerial Conference on Healthy Lifestyles and Noncommunicable Disease Control (Moscow, 28–29 April 2011), endorsed by the Sixty-fourth World Health Assembly (resolution WHA64.11), which requests the Director-General to develop, together with relevant United Nations agencies and entities, an implementation and follow-up plan for the outcomes of the Conference and the High-level Meeting of the United Nations General Assembly on the Prevention and Control of

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<sup>1</sup> United Nations General Assembly resolution 66/2.

Non-communicable Diseases (New York, 19–20 September 2011) for submission to the Sixty-sixth World Health Assembly; [WHA64.11, OP3.4]

PP5 Acknowledging also the Rio Political Declaration on Social Determinants of Health adopted by the World Conference on Social Determinants of Health (Rio de Janeiro, 19–21 October 2011), endorsed by the Sixty-fifth World Health Assembly (resolution WHA 65.8), which recognizes that health equity is a shared goal and responsibility and requires the engagement of all sectors of government, all segments of society, and all members of the international community, in “all-for-equity” and “health-for-all” global action; [PP2 of the Rio Political Declaration on Social Determinants of Health]

PP6 Recalling resolution EB130.R7, which requests the Director-General to develop, in a consultative manner, a WHO global action plan for the prevention and control of noncommunicable diseases for 2013–2020 and decision WHA65(8)<sup>1</sup> and its historic decision to adopt a global target of a 25% reduction in premature mortality from noncommunicable diseases by 2025; [WHA65(8), OP2 and OP8.5]

PP7 Reaffirming the leading role of the World Health Organization as the primary specialized agency for health, including its roles and functions with regard to health policy in accordance with its mandate, and reaffirming its leadership and coordination role in promoting and monitoring global action against noncommunicable diseases in relation to the work of other relevant United Nations agencies, development banks and other regional and international organizations in addressing noncommunicable diseases in a coordinated manner; [A/RES/66/2, PP13]

PP8 Acknowledging the contribution of international cooperation and assistance in the prevention and control of noncommunicable diseases, and in this regard, stressing the importance of North–South, South–South and triangular cooperation in the prevention and control of noncommunicable diseases, bearing in mind that South–South cooperation is not a substitute for, but rather a complement to, North–South cooperation; [A/RES/66/2, OP48, OP50]

PP9 Noting that noncommunicable diseases are often associated with mental disorders and that mental disorders often coexist with other medical and social factors [WHA65.4] and that, therefore, the implementation of the WHO action plan for the prevention and control of noncommunicable diseases 2013–2020 is expected to be implemented coherently and in close coordination with the WHO global mental health action plan 2013–2020 at all levels;

PP10 Welcoming the overarching principles and approaches of the global action plan (FOOTNOTE: as detailed in paragraph 18 of document A66/9) and calling for their application in the implementation of all actions to prevent and control noncommunicable diseases;

PP11 Recognizing that the United Nations Secretary-General, in collaboration with Member States, the World Health Organization and relevant funds, programmes and specialized agencies of the United Nations system is to present to the United Nations General Assembly at its sixty-eighth session a report on the progress achieved in realizing the commitments made in Political Declaration of the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases, in preparation for a comprehensive review and assessment in 2014 of the progress achieved in the prevention and control of noncommunicable diseases, [A/RES/66/2, OP65]

#### DECIDES:

OP1. to endorse the WHO global action plan for the prevention and control of noncommunicable diseases 2013–2020;

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<sup>1</sup> Decision WHA65(8), WHA65/2012/REC1.

OP2. to adopt the comprehensive global monitoring framework for the prevention and control of noncommunicable diseases, including the set of 25 indicators capable of application across regional and country settings to monitor trends and to assess progress made in the implementation of national strategies and plans on noncommunicable diseases, as detailed in Appendix I of document A66/8; [in response to A/RES/66/2, OP61]

OP3. to adopt the set of nine voluntary global targets for the prevention and control of noncommunicable diseases, as detailed in Appendix II of document A66/8, noting that the target related to a 25% relative reduction in overall mortality from cardiovascular diseases, cancer, diabetes or chronic respiratory diseases concerns premature mortality from noncommunicable diseases between ages 30 and 70, in accordance the corresponding indicator; [in response to A/RES/66/2, OP62].

OP4. URGES Member States [FOOTNOTE: And, where applicable, regional economic integration organizations]:

(1) to continue to implement the Political Declaration of the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases and strengthen national efforts to address the burden of noncommunicable diseases; [EB130.7 OP1.1, WHA61.14, OP2.1]

(2) to implement, as appropriate, the action plan and the proposed objectives and actions contained therein, by taking steps to implement such policies and plans, including through multisectoral national policies and plans for the prevention and control of noncommunicable diseases;

(3) to accelerate full Parties' implementation of the WHO Framework Convention on Tobacco Control (WHO FCTC), including through adopted technical guidelines, as well as to give high priority to the implementation of the Global Strategy on Diet, Physical Activity and Health (WHA57.17), the Global Strategy to Reduce the Harmful Use of Alcohol (WHA63.13), and the Recommendations on the Marketing of Foods and Non-alcoholic Beverages to Children (WHA63.14), as integral to making progress towards the voluntary global targets and realizing the commitments made in the Political Declaration of the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases; [Based on WHA60.23, PP2 and WHA61.14, OP2.5]

(4) to promote, establish, support and strengthen engagement or collaborative partnerships, including with non-health and non-state actors, such as civil society and the private sector, at the national, subnational and/or local levels for the prevention and control of noncommunicable diseases, as appropriate to country circumstances, with a broad multisectoral approach, while safeguarding public health interests from undue influence by any form of real, perceived or potential conflict of interest;

(5) to consider the development of national noncommunicable disease monitoring frameworks, with indicators based on national situations, and voluntary national targets as appropriate to national circumstances, taking into consideration, the comprehensive global monitoring framework, including the 25 indicators and the set of nine voluntary global targets, building on guidance provided by the World Health Organization, to focus on efforts to prevent and address the impacts of noncommunicable diseases, to support scaling up effective noncommunicable disease actions and policies, including technical and financial aspects, and to assess the progress made in the prevention and control of noncommunicable diseases and their risk factors and determinants; [updated from A/RES/66/2, OP63]

(6) to establish and strengthen, as appropriate, a national surveillance and monitoring system to enable reporting including against the 25 indicators of the comprehensive

global monitoring framework, the nine voluntary global targets and any additional regional or national targets and indicators for noncommunicable diseases;

(7) to recommend the United Nations Economic and Social Council to consider the proposal for a United Nations Task Force on Noncommunicable Diseases, before the end of 2013, which would be convened and led by WHO and report to ECOSOC, incorporating the work of the United Nations Ad Hoc Interagency Task Force on Tobacco Control while ensuring tobacco control is appropriately reflected in the new Task Force mandate;

(8) to support the work of the Secretariat to prevent and control noncommunicable diseases, including the implementation of the actions for the Secretariat included in the action plan, in particular through funding relevant work included in the Programme Budget 2014–2015; [based on WHA61.14, OP2.4]

(9) to continue to explore the provision of adequate, predictable and sustained resources, through domestic, bilateral, regional and multilateral channels, including traditional and voluntary innovative financing mechanisms and to increase, as appropriate, resources for national programmes for prevention and control of noncommunicable diseases; [A/RES/66/2, OP45.d and WHA60.23, OP4]

**OP5. REQUESTS the Director-General:**

(1) to submit detailed and disaggregated information on resource requirements necessary to implement the actions for the Secretariat included in the WHO global action plan 2013–2020, including financial implications for the establishment of a global coordination mechanism for the prevention and control of noncommunicable diseases, to a first financing dialogue convened by the Director-General and facilitated by the Chairman of the Programme, Budget and Administration Committee, on the financing of the proposed programme budget 2014–2015, with a view to ensuring that all partners have clear information on the specific funding needs, available resources and funding shortfalls of the actions for the Secretariat included in the action plan at the project or activity level; [based on EB132(16) and Annex]

(2) to develop terms of reference for a global coordination mechanism, pursuant to the principles and provisions outlined in paragraphs 14–15 of the WHO NCD Global Action Plan 2013–2020, aimed at coordinating implementation of recommended actions for international partners [FOOTNOTE: international partners are defined for this purpose as public health agencies with an international mandate, international development agencies, intergovernmental organizations (IGOs) including other United Nations organizations and Global Health Initiatives, international financial institutions (IFIs) including the World Bank, foundations, and nongovernmental organizations] included in the Global Action Plan, while safeguarding WHO and public health interests from undue influence by any form of real, perceived or potential conflict of interest, to be integrated into the work of WHO including leadership, convening authority and secretariat functions of the new mechanism, with an arrangement that is proportionate to the scope of its agreed objectives;

(3) to develop the terms of reference requested in OP5(2) through a structured Member State [FOOTNOTE: And, where applicable, regional economic integration organizations] consultation process, including regional committees, in collaboration with United Nations agencies, funds and programmes and other relevant intergovernmental organizations, and through engagement with nongovernmental organizations and private sector entities, and submit the draft terms of reference to the Sixty-seventh World Health Assembly, through the Executive Board for approval;

(4) to develop, in consultation with Member States and other relevant partners, a limited set of process indicators based on feasibility, current availability of data, best available knowledge and evidence and capable of application across the six objectives of

the action plan, to assess progress made in 2016, 2018 and 2021 in the implementation of policy options for Member States, recommended actions for international partners, and actions for the Secretariat included in the action plan, and submit the draft set of process indicators to the Sixty-seventh World Health Assembly, through the Executive Board for approval;

(5) to work together with other United Nations funds, programmes and agencies to conclude the work, before the end of October 2013, on a division of labour for United Nations Funds, Programmes and Agencies and other international organizations besides WHO contained in Appendix 4 of the action plan;

(6) to provide technical support to Member States, as required, to support the implementation of the WHO global action plan for the prevention and control of noncommunicable diseases;

(7) to provide technical support to Member States, as required, to establish or strengthen national surveillance and monitoring systems for noncommunicable diseases to support reporting under the global monitoring framework for noncommunicable diseases.

(8) to provide technical support to Member States, as required, to engage/cooperate with non-health government sectors and, in accordance with principles for engagement, with non-State actors [FOOTNOTE: Without prejudice to ongoing discussions on WHO engagement with non-State actors], in the prevention and control of noncommunicable diseases; [based on A/RES/66/2, PP3, OP39]

(9) To submit reports on progress made in implementing the action plan, through the Executive Board, to the Health Assembly in 2016, 2018 (FOOTNOTE) and 2021 (FOOTNOTE), and reports on progress achieved in attaining the nine voluntary global targets in 2016, 2021 and 2026.

(FOOTNOTE: The progress reports in 2018 and 2021 should include the outcomes of independent evaluation of the implementation of the global action plan conducted in 2017 and 2020.)

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

<b>1. Resolution:</b> Follow-up to the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases	
<b>2. Linkage to the Programme budget 2012–2013 (see document A64/7 <a href="http://apps.who.int/gb/ebwha/pdf_files/WHA64/A64_7-en.pdf">http://apps.who.int/gb/ebwha/pdf_files/WHA64/A64_7-en.pdf</a>)</b>	
Strategic objective(s): 3, 6 and 9	Organization-wide expected result(s): 3.1, 3.2, 3.3, 3.4, 3.6, 6.1, 6.2, 6.3, 6.4, 6.5, 9.1, 9.3 and 9.4
<b>How would this resolution contribute to the achievement of the Organization-wide expected result(s)?</b>	
The WHO global action plan for the prevention and control of noncommunicable diseases 2013–2020 includes a comprehensive set of policy options and actions for all stakeholders. These are presented under six objectives that, if effectively implemented, will: prevent and reduce disease, disability and premature death (Organization-wide expected result 3); promote health and development, and prevent or reduce risk factors (Organization-wide expected result 6); and improve nutrition, throughout the life-course, and support public health and sustainable development (Organization-wide expected result 9).	
<b>Does the Programme budget already include the products or services requested in this resolution? (Yes/no)</b>	
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) Eight years, covering the period 2013–2020

(ii) US\$ 75 million (2013), US\$ 192 million (2014–2015), US\$ 230 million (2016–2017), US\$ 276 million (2018–2019) and US\$ 165 million (2020)

**(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).**

US\$ 75 million (US\$ 45 million for staff and US\$ 30 million for activities)

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

At the three levels of the Organization.

**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.

**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.**

Staffing at the three levels of the Organization needs to be scaled up. Posts that are currently vacant need to be filled.

**4. Funding**

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

No.

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

US\$ 30 million would be required to complete continuing activities for the full implementation of the action plan for the global strategy for the prevention and control of noncommunicable diseases (endorsed by the Health Assembly in resolution WHA61.14), covering the period 2008–2013. This figure includes US\$ 10 million for critical work in 2013 to enable the Organization to start delivering the activities included in the global action plan for the prevention and control of noncommunicable diseases 2013–2020.

Dr EL OAKLEY (Libya) said that the draft resolution proposed by the delegations of Australia, Canada, China, Colombia, Costa Rica, Finland, Libya, Malaysia, Mexico, Monaco, Norway, Russian Federation, Singapore, Uruguay and the United States of America was an omnibus text that built on the draft resolutions contained in documents A66/8 and A66/9.

He suggested that a drafting group should be tasked with reaching consensus on a final text for consideration by the Committee. The group would need to devote considerable attention to several sensitive issues touched upon in the draft resolution, including those relating to future reporting and the preparation of terms of reference for a global coordination mechanism. Nevertheless, he was confident that the political will existed to fulfil the mandate entrusted to WHO by the Political

Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases.

Mr KULIKOV (Russian Federation) said that in recent years Member States had made significant progress in implementing the provisions of both the Moscow Declaration on Healthy Lifestyles and Noncommunicable Disease Control and the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases. He endorsed the global monitoring framework and targets for the prevention and control of noncommunicable diseases and the draft action plan for the prevention and control of noncommunicable diseases 2013–2020, contained in documents A66/8 and A66/9, respectively. He supported the establishment of a drafting group to harmonize the text of the proposed draft resolution on follow-up to the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases and proposed the delegate of the United States of America as its chairman.

Ms LANTERI (Monaco) expressed support for the establishment of a drafting group with Mr McIff (United States of America) as its chairman.

Mr WANGDI (Bhutan), speaking on behalf of the Member States of the South-East Asia Region and drawing attention to the severe impact of noncommunicable diseases on those Member States, thanked the Secretariat for facilitating the preparation of the draft comprehensive global monitoring framework and the draft action plan for the prevention and control of noncommunicable diseases. He also expressed appreciation to the Member States and international agencies that had contributed to that work through formal, informal and web-based consultations. He observed that the voluntary global targets set out in the comprehensive global monitoring framework were very ambitious, particularly for low- and middle-income countries. Nevertheless, at the technical consultation in February 2013, the Member States of the Region had agreed to integrate the global targets into regional targets, and had been urged to prepare voluntary national targets and indicators and to strengthen their surveillance and information systems. As baseline data and monitoring frameworks were not available in many countries, it had been agreed that the voluntary targets and indicators would be revisited before the end of 2015. Setting up national targets, drawing up and strengthening national action plans for the prevention and control of noncommunicable diseases, and strengthening monitoring and surveillance systems required technical capacity. He therefore requested the Secretariat to continue mobilizing resources to meet the demands of developing countries in particular. Prevention and control of noncommunicable diseases needed to be included in the post-2015 development agenda.

Professor BAGGOLEY (Australia) strongly supported adoption of the global monitoring framework and a set of voluntary global targets as agreed at the formal meeting of Member States in 2012. He called on the Secretariat to support Member States at regional and country levels in undertaking implementation and in reporting on progress against the established indicators and targets. He particularly welcomed the focus on equity in the monitoring framework as a prerequisite for achieving the global goal of reducing poverty. He commended the outcomes of the consultations with Member States and other actors in preparing the draft action plan and said that he would support the addition of specific actions on palliative care and end-of-life issues. The draft action plan for 2013–2020 provided a vision for future action on noncommunicable diseases that built on the achievements of the 2008–2013 action plan. He looked forward to its adoption by the Health Assembly.

He expressed approval of the clear linkages between the draft action plan and draft global monitoring framework and existing strategies on tobacco, alcohol, diet and physical activity, and he particularly supported the element of flexibility in the action plan that would allow Member States to select activities that were best suited to national circumstances. The clearly defined role of non-State actors in the plan would contribute to WHO's work in delivering a comprehensive global response to

noncommunicable diseases. As a sponsor of the proposed draft resolution under consideration, Australia supported the establishment of a formal drafting group to be chaired by the delegate of the United States of America, Mr McIff.

Ms GRØNVOLD (Norway) noted with satisfaction the comprehensive follow-up work that had been carried out since the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases in September 2011 and, in particular, that WHO was on track to fulfil the commitments undertaken. Recalling the agreement reached at the formal meeting of Member States, in November 2012, on the comprehensive global monitoring framework, including 25 indicators and nine voluntary targets, she urged the Health Assembly to adopt the proposed framework contained in document A66/8, without amendment, as part of the draft action plan for the prevention and control of noncommunicable diseases 2013–2020, which provided a point of departure for further discussions. She supported the proposal to establish a drafting group and strongly urged delegates to participate in the negotiations with the clear intention of agreeing on a text.

Dr NGOC KHUE LUONG (Viet Nam) welcomed the comprehensive draft action plan contained in document A66/9 but suggested that there be a sharper focus on certain key elements, such as supporting developing countries in reducing the burden posed by cardiovascular diseases. With regard to objective 2 in the Annex to the document, developing countries should be given guidance in preparing a comprehensive multisectoral plan for dealing with all noncommunicable disease risk factors. Turning to objective 3, he suggested that the second priority risk factor for noncommunicable disease, after tobacco use, be identified as high salt/sodium intake. Under objective 6, Member States should identify national institutions with responsibility for coordinating noncommunicable disease surveillance, in order to reduce duplication of activities.

Mr ISLAM (Bangladesh) said that the draft global monitoring framework and voluntary targets and indicators provided a clear picture of noncommunicable disease risk factors and their global impact, but many countries lacked the ability to measure the indicators. Moreover, voluntary targets provided an excuse for some countries not to adopt and implement the framework. He therefore requested the Secretariat to mobilize additional resources, carry out strong policy advocacy, particularly in developing countries, and provide technical support in order to enable effective noncommunicable disease surveillance systems to be established. Member States of the South-East Asia Region had agreed to work towards setting common targets, indicators and monitoring frameworks, for which adequate technical support would be needed. Such support was also needed to strengthen the existing national disease and risk factor surveillance system and the national health information system in Bangladesh.

Dr SEAKGOSING (Botswana), speaking on behalf of the Member States of the African Region, noted that the overwhelming burden of infectious diseases was preventing many African countries from devoting sufficient attention to the increasing incidence of chronic noncommunicable diseases, with the result that progress in socioeconomic and human development in Africa remained highly constrained. He therefore welcomed the emphasis placed in the draft action plan on the operationalization and implementation of the various commitments undertaken. Differences between countries in the levels of socioeconomic development and prevention and control of noncommunicable diseases called for the framework set out in the action plan to be adapted to specific regional and national situations, legislation and priorities.

Bearing in mind the impact of noncommunicable diseases on areas other than health, he highlighted the role of international partners in enabling Member States to achieve the targets and indicators included in the framework, and urged WHO and other organizations of the United Nations system to provide technical support in order to ensure a whole-of-society, a health-in-all-policies and a whole-of-government approach to prevention and control efforts. Noting that some countries were still lagging behind in the implementation of the 2008–2013 action plan for the global strategy for the

prevention and control of noncommunicable diseases, he called for support to be provided for evaluating existing strategies and devising new ones in line with the draft action plan for the prevention and control of noncommunicable diseases 2013–2020. Although implementation of the draft action plan would bring undoubted benefits, he expressed concern at the informal nature of the consultation process and requested that a drafting group be set up to review the draft resolution contained in document A66/9.

Dr KESKINKILIÇ (Turkey) welcomed the draft resolution on follow-up to the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases. The choice of indicators contained in Appendix 1 to document A66/8 appeared to be a judicious one, but it should be recognized that the relevant criteria could be affected by future scientific developments. More emphasis should be placed on targets as effective tools for improving the quality of life globally. Highlighting the importance of universal coverage, he said that programmes for controlling chronic diseases needed to include health promotion, protection and early diagnosis. Health systems should provide improved coverage for effective treatment, management of complications and palliative therapy. Referring to the target of reducing premature mortality from noncommunicable diseases and its indicator in relation to data on life expectancy contained in *The world health report 2012*, he warned against admitting failure before work had begun.

Professor COLL SECK (Senegal) said that the draft comprehensive global monitoring framework and set of 25 indicators would be useful tools for making comparisons between countries. She stressed, however, that the indicators should be region- and country-specific. Although the targets were both necessary and relevant, in some cases financial and technical support would be needed to strengthen noncommunicable disease monitoring systems as a prerequisite for the establishment of a comprehensive global monitoring framework. She welcomed most aspects of the draft global action plan but said that it should place particular emphasis on the promotion of local production, wider access to affordable medicines, public–private partnerships, training of human resources and support to low-income countries. Further discussions on the global monitoring framework should be conducted in a more collaborative and inclusive manner.

Dr ALHAJERI (Bahrain) said that, together with health promotion, noncommunicable diseases were treated as a priority in Bahrain's health strategy and that its widely supported national plan of action for combating those diseases, which was essentially based on WHO's action plan for the global strategy for the prevention and control of noncommunicable diseases, stemmed from its commitment to implementation of the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases. Composed of relevant stakeholders, a national committee on noncommunicable diseases had been formed in 2012 and the national action plan and its indicators were currently being aligned with WHO's draft action plan for 2013–2020. Given the growing prevalence of noncommunicable diseases and their risk factors, efforts had been made to strengthen the health system, in particular at the primary health care level, including through the establishment of a monitoring and detection system and the facilitation of universal access to medical care, without discrimination. Committed as it was to applying the highest standards with respect to early detection and treatment, the prevention of complications, and patient rehabilitation, Bahrain would pursue those efforts with a view to attaining the performance indicators suggested in the global monitoring framework. He supported adoption of both the draft action plan and the draft comprehensive global monitoring framework and targets for the prevention and control of noncommunicable diseases, and called for the development of a mechanism for evaluating Member States' progress in implementing the Political Declaration.

Dr SADRIZADEH (Islamic Republic of Iran), speaking on behalf of the Member States of the Eastern Mediterranean Region, welcomed the draft global action plan for the prevention and control of noncommunicable diseases 2013–2020, whose aim was to operationalize the commitments set out in

the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases. Since current resource constraints could hamper implementation of the plan, a set of priority actions for countries at different levels of development should be identified. In view of the fact that effective noncommunicable disease prevention and control depended on able leadership and strong multisectoral involvement, WHO's guidance and support would be needed in scaling up whole-of-government and health-in-all-policies approaches. The Regional Committee for the Eastern Mediterranean had recently adopted resolution EM/RC59/R.2, which included a regional framework for action that focused on scaling up implementation of the commitments set out in the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases. The draft action plan contained in document A66/9 would provide support for implementation of the regional resolution and framework. In that context, greater emphasis should be placed on: enhancing national capacities; strengthening noncommunicable surveillance systems and facilitating their integration in national health information systems; establishing a multisectoral action plan for prevention and control of noncommunicable diseases; preparing cost-effective, evidence-based preventive interventions; prioritizing primary health care-based approaches to the management and screening of noncommunicable diseases; and devising a "best-practice" model for primary health care.

He urged the Secretariat to provide technical support to Member States to enable them to implement the global action plan. Particular attention should be paid to establishing and strengthening national surveillance systems and engaging with non-health sectors in accordance with the relevant principles of engagement.

Dr DEVLIN (Ireland), speaking on behalf of the European Union and its Member States, emphasized the need for a systemic, whole-of-government approach to dealing with noncommunicable diseases and their risk factors. WHO should also take an integrated approach to implementation of the draft global action plan, the global strategy to reduce the harmful use of alcohol, the global strategy on diet, physical activity and health, and the recommendations on the marketing of foods and non-alcoholic beverages to children. In order to ensure systematic and comprehensive reporting, a single progress report that included data on the WHO Framework Convention on Tobacco Control should be produced through a streamlined process. The Secretariat should devise a means of measuring progress towards achieving the global voluntary targets that focused on policy measures and actions and used existing data. The proposed incorporation of the mandate of the United Nations Ad Hoc Interagency Task Force on Tobacco Control into a United Nations Task Force on Noncommunicable Diseases would be helpful in coordinating the efforts of different United Nations agencies.

The terms of reference of the proposed global coordination mechanism could specify that WHO should convene, host and lead a light process that would be guided by the principles that applied to participation in WHO's work by non-State actors. Future actions in that area should form part of a transparent and structured process. The European Union would participate constructively in the work of the proposed drafting group.

Dr USHIO (Japan) said that, following web consultations and formal meetings on the issue, the Health Assembly should be in a position to adopt the draft comprehensive global monitoring framework. He encouraged the Secretariat and Member States to step up their efforts to achieve the targets under the draft action plan for the prevention and control of noncommunicable diseases by 2025. In particular, the Secretariat should endeavour to standardize data collection methods and improve data accuracy, with due regard for feasibility and the financial and administrative burden on each country. Japan stood ready to provide support for the implementation of the draft action plan in collaboration with other international partners.

Dr MARTINEZ DE CUELLAR (Paraguay) strongly supported the indicators and targets for the global comprehensive monitoring framework, as they were essential to the development of a global strategy and global and regional action plans. Paraguay was in the process of developing a national action plan taking into account the global framework and attached high priority to enhanced monitoring of noncommunicable diseases.

Ms EVLEGSUREN (Mongolia) said that, once the draft global monitoring framework was adopted, Member States would be required to produce comprehensive progress reports, by revising existing programmes and data collection tools and strengthening national surveillance systems and national capacities to analyse data and translate the results into policy recommendations. Mongolia was already reporting on 17 of the 25 proposed indicators, and another two were in the process of being added to the system. However, technical and financial support from WHO was needed to improve data quality. Although Mongolia was willing to adopt the nine voluntary global targets for the prevention and control of noncommunicable diseases, some of them were extremely ambitious. The draft action plan represented a unique opportunity for countries to reflect global objectives in their national policies, and her country was revising its current action plan in the light of the global action plan. Regarding policy options under the plan, Mongolia considered the harmful use of alcohol to be a priority topic and she requested that it be placed on the agenda of the Sixty-seventh World Health Assembly as a separate item, requiring efforts as strong as those for tobacco control.

Dr HARVEY (United Kingdom of Great Britain and Northern Ireland) said that greater efforts were required to tackle noncommunicable diseases through multisectoral and multi-stakeholder activities. Although it was important to guard against conflicts of interest, Member States should not be deterred from mobilizing all resources that could produce positive results. Action was needed in all areas, including primary prevention, early detection and intervention, compassionate treatment and high-quality palliative care. It was important to address the risk factors for noncommunicable diseases, while supporting people already suffering from such diseases. Her country was taking steps to reduce salt and calorie intake and introduce a system of health checks to help to manage vascular risks. She fully supported the adoption of the draft global monitoring framework and targets and the draft action plan. In general, using process measures to monitor progress was a positive approach, but such measures should use existing mechanisms so as not to place additional burdens on Member States and the Secretariat.

Dr NYARKO (Ghana) said that the countries of the African Region, recognizing the major burden of noncommunicable diseases, had met in Nairobi in 2012 to review the draft global monitoring framework on the basis of experience in the African setting. Concerns had been raised about the lack of baseline data for indicators related to alcohol, fat and salt intake, availability of medicines for noncommunicable diseases and vaccination against human papillomavirus. Moreover, additional indicators had been proposed in relation to specialized treatments such as radiotherapy and psychological care. At the Sixth Conference of African Union Ministers of Health (Addis Ababa, 22–26 April 2013), it had been agreed that the high cost of managing noncommunicable diseases meant that prevention was the most viable option for tackling risk factors such as tobacco use, alcohol consumption, reduced physical exercise and unhealthy diet. Health system strengthening, resource mobilization, appropriate legislation and the adoption of a multisectoral approach had been identified as key ways of moving the noncommunicable disease agenda forward. The draft framework would be an important tool for monitoring progress in the implementation of prevention and control activities. The monitoring of indicators should be guided by the key dimensions of equity, including gender, age and socioeconomic status, as well as key social determinants such as income level and education. The African Region faced a number of challenges in its efforts to prevent and control noncommunicable diseases, including in particular the lack of human, material and financial resources and a low level of interest in the issue among development partners. To address those challenges, it would be necessary to develop a good surveillance system for noncommunicable diseases, increase functional partnerships

with development partners and build the capacity of health professionals to prevent and control such diseases.

Dr KOH (United States of America) endorsed the draft global monitoring framework, which should be adopted without amendment. In developing that framework, WHO had fulfilled the first of its responsibilities under the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable diseases. He welcomed the progress made in refining a global action plan for the prevention and control of noncommunicable diseases through a collaborative, multi-stakeholder process. The draft action plan provided a strong basis for action to reduce disability, morbidity and premature mortality resulting from noncommunicable diseases. Adding a limited number of process indicators to the global monitoring framework would further strengthen monitoring of implementation of the action plan. He encouraged the Secretariat to provide support to Member States in evaluating interventions on the basis of the best current knowledge, including relevant WHO tools adapted to national contexts. The draft action plan should be sufficiently flexible to incorporate new scientific evidence during the course of its implementation. Multisectoral action was crucial for the prevention and control of noncommunicable diseases, and WHO should play a leading role in a global mechanism to promote engagement, international cooperation and collaboration among relevant stakeholders, a mechanism organized around outcomes rather than the functional gaps referred to in document A66/9.

Mr THAUFEEQ (Maldives) said that the prevention and control of noncommunicable diseases required a holistic, rational and cost-effective approach. For his country, overcoming geographical constraints and providing access to diagnostics and services for noncommunicable diseases remained key challenges. Tobacco control was one of the most cost-effective strategies to reduce the burden of noncommunicable diseases, and there was growing public support for the enforcement of tobacco legislation in Maldives, despite obstacles raised by the tobacco industry. Regional and international collaboration was crucial to meeting the proposed targets, including through collective action against advertisements for harmful goods, the harmonization of tobacco taxes and the strengthening of anti-smuggling measures. Small countries with limited markets should also join together to explore the benefits of pooled procurement of essential medicines. He called for more collaboration and research into the cost-effectiveness of current interventions, together with the exchange of information on best practices.

The CHAIRMAN called on the Legal Counsel to provide guidance on the constitution of a drafting group to refine the draft resolution on follow-up to the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases.

Mr SOLOMON (Office of the Legal Counsel) explained that documents A66/8 and A66/9 contained skeleton resolutions which had been drafted by the Secretariat in response to requests from the Executive Board at its 132nd session. A non-paper, which was the product of informal consultations, was also available in all official languages. The Committee might wish to establish a drafting group to consider the draft resolution tabled by the United States of America and other countries in conjunction with the texts in documents A66/8 and A66/9 that would take into account, as appropriate, the non-paper and any other suggestions or proposals from Member States.

Dr SAEEDI (Saudi Arabia) proposed that Dr Nishtar of Pakistan should co-chair the drafting group.

Dr DIXON (Jamaica) said that the member countries of the Caribbean Community had been instrumental in having noncommunicable diseases placed on the agenda of the United Nations General Assembly. The High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable diseases had given direction to WHO to fulfil a number of requirements and Member

States, including members of the Caribbean Community, had contributed to the drafting of decision WHA65(8) on prevention and control of noncommunicable diseases: follow-up to the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases, which had set a global target of a 25% reduction in premature mortality from noncommunicable diseases by 2025. She welcomed the establishment of a drafting group, the membership of which should include a representative of the Caribbean Community.

The CHAIRMAN said that it was his understanding that Mr McIff of the United States of America and Dr Nishtar of Pakistan had been nominated as possible chairs of the drafting group.

Mr CORRALES (Panama) expressed concern that a decision was being taken that affected the delegation from Pakistan, even though they were not present in the room at that time.

Mrs ESCOREL DE MORÃES (Brazil) requested confirmation that the drafting group would have two co-chairs. In addition, she requested that the group should start its work as soon as possible.

Dr ARMSTRONG (Secretary) confirmed that there would be two co-chairs: Mr McIff of the United States of America and Dr Nishtar of Pakistan. The delegation of Pakistan had been consulted on the issue and was in full agreement. However, for logistical reasons, it would not be possible for the drafting group to start its work before the evening of the next day.

Mrs ESCOREL DE MORÃES (Brazil) requested clarification on the mandate of the drafting group. She understood that the group would review the draft action plan for the prevention and control of noncommunicable diseases 2013–2020 and the draft resolution. The draft action plan would be one of the most important outcomes of the Sixty-sixth World Health Assembly and should therefore be the subject of thorough and unhurried discussion.

Dr ARMSTRONG (Secretary) said that the mandate of the drafting group would be to review the draft resolution and address any outstanding issues in relation to the draft action plan.

Dr NABEEL (Pakistan) confirmed that the head of his delegation was willing to co-chair the drafting group.

The CHAIRMAN took it that the Committee wished to establish a drafting group to review the draft resolution and address any outstanding issues in relation to the draft action plan.

**It was so agreed.**

Dr MAHIPALA (Sri Lanka) said that the rapid spread of noncommunicable diseases throughout the world was becoming an obstacle to national development. In Sri Lanka, noncommunicable diseases were particularly prevalent as a result of physical inactivity, poor eating habits, smoking and alcohol consumption; national strategies had therefore been initiated to prevent and control the spread of such diseases. They included a programme launched in April 2012 that focused on the importance of alleviating malnutrition and developing health-conscious infrastructure throughout the country, for example through the building of special walkways and jogging lanes to encourage healthier lifestyles. The draft global monitoring framework would help to strengthen national capacities and reduce the burden of noncommunicable diseases throughout the world. However, it was important that the framework was considered in relation to national situations, initiatives, targets and indicators in order to be an effective tool for Member States. He highlighted the importance of placing noncommunicable diseases on the post-2015 development agenda.



Dr FEISUL IDZWAN MUSTAPHA (Malaysia) observed that it would be a challenge for even fast-developing countries such as Malaysia to strengthen their systems for monitoring the indicators provided for in the draft global monitoring framework. Funding should therefore be specifically allocated to strengthening surveillance of noncommunicable diseases, and the Secretariat should ensure that adequate resources were allocated to Member States requiring assistance in that regard. Malaysia welcomed the proposed WHO global coordination mechanism on noncommunicable diseases and the development of a set of process indicators. He urged all Member States to participate in the work of the drafting group.

Dr RAMOKGOPA (South Africa) said that, instead of a voluntary approach to monitoring and reporting, emphasis should be placed on the need to strengthen WHO as a multilateral forum that helped countries in their coordination and monitoring efforts. With regard to risk factors, the globalized nature of industry meant that Member States and the Secretariat should work together to ensure that poorer countries did not receive lower quality products, particularly dumped food and medicines. In addition, the scope of current surveillance mechanisms and treatment approaches for noncommunicable diseases needed to be expanded to include children and adolescents; programmes would be greatly enhanced if more was known about risk behaviour, as such behaviour often started early in life.

Ms ORRATHAI WALEEWONG (Thailand) said that translating global commitments into concrete actions and positive outcomes would be a major challenge in relation to the comprehensive global monitoring framework and the draft global action plan. Targets needed to be developed at the subnational, national and regional levels, together with effective implementation strategies. WHO would play a vital leadership and support role in that regard, particularly for developing countries. It was important for countries to establish baseline data and set up national monitoring and surveillance mechanisms. WHO should provide guidance on national targets, standard definitions for each indicator and target, and indicators for global reporting. A mechanism for reporting and information sharing between Member States should also be developed. Although multisectoral collaboration was vital for the prevention and control of noncommunicable diseases, it was important to ensure that such collaboration was free from conflicts of interest and that public health interests were safeguarded. The rules governing conflict of interest should apply to both the private and public sectors.

Dr AL LAMKI (Oman) welcomed inclusion of the 25 indicators and the set of nine voluntary global targets in the draft comprehensive global monitoring framework; the framework was realistic, as was the draft action plan. He supported the adoption of both those tools and also strongly endorsed the report of the Formal Meeting of Member States, annexed to document A66/8.

Dr WAIHENYA (Kenya) said that he had concerns about the dearth of baseline data for some indicators and risk factors. Moreover, the lack of adequate resources and relevant policies would make it difficult for some countries to fulfil their reporting requirements. Continued technical support was required in that regard, particularly for regular surveys. He expressed support for the establishment of a global coordination mechanism since the implementation of strategies geared to prevention and control would require a coordinated approach.

Dr PRIMA YOSEPHINE (Indonesia) said that it was extremely important to monitor epidemiological trends with regard to noncommunicable diseases and to assess the impact and cost of prevention and control strategies at all levels. Some of the proposed targets and indicators in the draft global monitoring framework needed further refinement with a view to developing effective and efficient programmes. As one of the largest archipelagic countries in the world, Indonesia was uniquely placed to evaluate the effect of factors such as geographical location, population distribution and access to health care for the prevention and control of noncommunicable diseases. Any action plan should be dynamic and adjustable to national situations. The draft global monitoring framework would

provide a good basis for the development of national frameworks that used country-specific indicators and targets that were achievable and easy to monitor.

Dr DA COSTA (Panama) said that his country was working hard to produce a plan on noncommunicable diseases and welcomed the draft global monitoring framework. However, he was concerned about the indicator relating to access to palliative care, as the use of death from cancer as a measure could be confusing and lead people to believe that palliative care was only available to those suffering from cancer. It was important to refine and improve that indicator.

(For continuation of the discussion, see the summary record of the eleventh meeting, section 2.)

**The meeting rose at 17:40.**

## **SECOND MEETING**

**Tuesday, 21 May 2013, at 09:15**

**Chairman:** Dr W.T. GWENIGALE (Liberia)

### **1. PROGRAMME AND BUDGET MATTERS:** Item 12 of the Agenda

**Implementation of Programme budget 2012–2013: interim report:** Item 12.1 of the Agenda (Documents A66/5 and A66/51)

Dr THABET NASHER (Yemen), speaking in his capacity as Chairman of the Programme, Budget and Administration Committee, introduced the Committee's report contained in document A66/51. The Committee had recommended, on behalf of the Executive Board, that the Health Assembly note the interim report on implementation of the Programme budget 2012–2013.

**The Committee noted the report.**

**Draft twelfth general programme of work:** Item 12.2 of the Agenda (Documents A66/6, A66/6 Add.1 and A66/52)

The CHAIRMAN invited the Committee to consider the draft resolution contained in document A66/52, which included the amendments proposed by the Programme, Budget and Administration Committee.

Dr THABET NASHER (Yemen), speaking in his capacity as Chairman of the Programme, Budget and Administration Committee, introduced the Committee's report contained in document A66/52. The Committee recommended, on behalf of the Executive Board, that the Health Assembly adopt the amended draft resolution contained in document A66/52.

Dr USHIO (Japan), expressing support for the draft twelfth general programme of work, commended the open and inclusive consultation process which had enabled Member States' comments to be reflected in the document. He endorsed the proposed six leadership priorities but requested clarification as to how the five programmatic categories would contribute to the achievement of those priorities, in particular the ones related to universal health coverage and the social determinants of health, both of which spanned several categories of work. He suggested that, once finalized, the matrix on the relationship between the six core functions of WHO and the roles and responsibilities of the three levels of the Organization should be included in the draft twelfth general programme of work. He further suggested the inclusion of an impact goal on universal health coverage, in view of its importance and the need to monitor progress in that area.

Ms HAGERTY (Ireland), speaking on behalf of the European Union and its Member States, commended the Secretariat's work in developing the draft twelfth general programme of work, which reflected a new chapter for global health. The six leadership priorities provided a clear strategic vision and direction for the Organization and would stimulate the global dialogue on key public health issues. Supporting the report's balanced attention to existing and emerging health challenges, she welcomed the continued focus on the health-related Millennium Development Goals, universal health coverage and the International Health Regulations (2005), as well as the new emphasis on noncommunicable

diseases, and trusted that the Secretariat would give due consideration to the emerging issue of antimicrobial resistance. She also welcomed the commitment to a constant financial envelope of US\$ 12 billion across the three bienniums of the draft twelfth general programme of work and the development of a fully costed budget framework for the biennium 2016–2017. Maintaining consistency in the organization of work and budget structures would allow WHO to compare the results achieved over the next three bienniums. She expressed appreciation for the improved clarity and streamlining of the results chain and the application of core functions. Work on results-based management and the results chain must continue over the lifetime of the twelfth general programme of work. She looked forward to the finalization of the impact and outcome targets and indicators for 2019 and to continued engagement with the governing bodies in that regard.

The adoption of the draft twelfth general programme of work would mark the culmination of the Organization's work on the programme and priority-setting elements of WHO reform, and she welcomed the document's emphasis on governance and management reform. With regard to management reform, the strengthening of country offices must go hand in hand with increased accountability.

She looked forward to the forthcoming discussions on internal governance by the Executive Board at its 133rd session and supported all measures to improve the management of agenda items and draft resolutions.

Mrs TYSON (United Kingdom of Great Britain and Northern Ireland) welcomed the progress made in the area of WHO reform and broadly endorsed the draft twelfth general programme of work.

Mr MAMACOS (United States of America), noting that the draft twelfth general programme of work was a pivotal reform document, highlighted the need to ensure that it had the necessary flexibility to capture emerging health issues. At the eighteenth meeting of the Programme, Budget and Administration Committee, his delegation had proposed several amendments to the text of the draft twelfth general programme of work, which, if accepted, could also be used in the programme budget. In paragraph 100, he also suggested deleting the words "including work in health and other sectors to prevent the further development of antimicrobial resistance" and inserting a new paragraph 100*bis* to read: "Innovation to create new products must be matched by measures to prevent the further development and spread of antimicrobial resistance (AMR). AMR kills. It hampers the control of infectious diseases and it dramatically increases the costs of health care. In the absence of urgent action, current health gains are threatened and the world faces the prospect of a return to a pre-antibiotic era, with the economic and social consequences that this implies. AMR is a complex problem driven by many interconnected factors; single isolated interventions will therefore have limited impact. Rather, a global and national multisectoral response is absolutely essential." He encouraged Member States to accept the proposed amendments in view of the global importance of the issue of antimicrobial resistance.

Mr ELIRA-DOKEKIAS (Congo) welcomed the Executive Board's observations regarding the decrease in the level of budget allocation for communicable diseases and in the allocation to the Member States of the African Region, which continued to require substantial support. It was very important that the focus on noncommunicable diseases should not be at the expense of the commendable, but as yet insufficient, results achieved by African Member States in the fight against communicable and neglected tropical diseases. In that context, work on WHO reform should continue, with an emphasis on effective management and transparency, despite the current global financial challenges. The efforts expended and results achieved over the past 10 years must not be overlooked, and WHO should continue to provide support to African Member States and country offices in the Region in order to strengthen their fragile health systems.

Ms CHERQAOU (Morocco) said that document A66/6 provided a high-level strategic vision for the work of WHO, particularly with respect to the establishment of leadership priorities and the

means by which WHO could be held accountable for the way resources were used to achieve specified results, with three successive programme budgets setting out the detail of what would be achieved in each biennium. The draft general programme of work commendably built on lessons learnt from the Eleventh General Programme of Work and, as requested by Member States, it incorporated key elements of the former Medium-term strategic plan 2008–2013. Chapters 1 and 2 contained a valuable analysis of the political, economic and institutional context, and the implications for WHO must be taken into account. She endorsed the content of chapters 3, 4, and 5 and expressed satisfaction with the draft general programme of work as a whole. More flexible financing was needed, and the definition of indicators should take into account country specificities and priorities, in order to achieve the desired outcomes.

Ms WISEMAN (Canada) commended the improvements incorporated in the draft twelfth general programme of work, which contained clear priorities to guide the future work of the Organization. She endorsed the leadership priorities, particularly those addressing the health-related Millennium Development Goals, noncommunicable diseases and the implementation of the International Health Regulations (2005), and welcomed the inclusion of further detail on the scope of the priorities. The draft twelfth general programme of work would play a central role in the WHO reform process and provide the framework needed to enhance alignment between the three levels of the Organization. She expressed support for the amendments proposed by the delegate of the United States of America.

Mr LI Mingzhu (China) supported the draft twelfth general programme of work but observed that the wording proposed by his delegation at the eighteenth meeting of the Programme, Budget and Administration Committee had not been included in the Committee's report (document A66/52). He requested the Secretariat to rectify that omission. Endorsing the positive aspects of the new financing model outlined in the document, he noted the current dominance of voluntary contributions, which were unpredictable and unstable. Given that predictable, stable funding was required to achieve the objectives of the programme of work, it was necessary to increase the flexibility of voluntary contributions and earmarked funding; the zero nominal growth of the assessed contributions should not continue, and a small, but sustained, increase of assessed contributions needed to be considered, in order to contain the trend of a growing imbalance of the budget structure. He expressed support for the draft resolution contained in document A66/6 Add.1.

Dr ST. JOHN (Barbados) said that the draft twelfth general programme of work was a well-structured and carefully researched plan, in which the Secretariat had focused on the Organization's comparative advantage in setting the global health agenda, taking into account the priorities outlined by Member States. She urged the Director-General to continue sharpening that focus. In cooperation with its partners, WHO must enhance its role as a global "watchdog" in order to take forward the work on social determinants of health. It was essential to take account not only of the global health agenda but also of the varying country-level needs when determining resource allocation under the programme of work. The extent to which elements of the programme of work were incorporated into national strategic plans would be a measure of the success achieved in translating the global health agenda into national health agendas. She expressed support for the amendment proposed by the delegate of the United States of America on the issue of antimicrobial resistance.

Ms BOTERO HERNANDEZ (Colombia) supported the draft twelfth general programme of work, which reflected the progress made towards achieving the objectives of the WHO reform process. She welcomed the additional programme areas included in the document and the inclusion of a results chain, which clearly represented the relationship between outputs and results. She suggested including a timetable differentiating between short- and long-term actions and accompanied by an allocation of resources that took account of current Organization-wide funding constraints.

Dr IDRIS (Nigeria) expressed support for the draft twelfth general programme of work. The programme goals set out in the document were highly relevant to the ongoing work in his country to improve the health of its citizens. Noting the emphasis placed on eradicating dracunculiasis, he said that other neglected tropical diseases of equal importance, such as schistosomiasis, should also be addressed in the draft programme of work.

Dr SAÍDE (Mozambique), speaking on behalf of the Member States of the African Region, said that the draft twelfth general programme of work established the vision and goals of the Organization and would facilitate the implementation of WHO reform. However, he expressed concern at the unpredictable nature of WHO funding and its implications for the successful delivery of programmes and for the associated need to retain qualified and experienced staff. He therefore fully supported efforts to enhance the predictability of funding and in particular to ensure a better balance between voluntary and assessed contributions. Additional technical and financial resources could be secured by strengthening partnerships and collaboration, which in turn would improve the implementation of health priorities at the country level.

Mr SVERSUT (Brazil) said that the draft twelfth general programme of work would enhance the efficiency of the Organization and facilitate improved outcomes on a global level. Brazil had proposed amendments to the text, which were contained in the Annex to the report of the Programme, Budget and Administration Committee under discussion and which he commended for adoption. He requested that the Secretariat compile the amendments that had been verbally proposed by other Member States at the current meeting into a document or multimedia presentation so that other delegations could consider them in further detail.

Dr SHOHANI (Iraq) shared the view of countries in the Eastern Mediterranean Region that budget allocations at the regional and country levels should be made on the basis of the disease burden and the needs and specificities of each society. The budget allocation for the control of noncommunicable diseases should be at least double the current amount, in order to tackle the growing burden of those diseases and counter the risk factors. Such a budget increase would also have a positive impact on communicable diseases. Efforts to strengthen the control and prevention of noncommunicable diseases, particularly with respect to epidemiological and laboratory investigations, should be carried out in parallel, which would in turn promote the epidemiological investigation of communicable diseases and was essential to attainment of the Millennium Development Goals.

Mr RAO (India) welcomed the well-structured, robust draft twelfth general programme of work which provided seamless coverage of issues ranging from the programmatic, governance and management elements of WHO reform to the core functions and responsibilities of all levels of the Organization and the priorities for the coming years. Commendably, the document recognized that much remained to be done in improving health outcomes and that economic progress should not be measured only in terms of averages. However, he would have preferred a more detailed framework for monitoring and evaluating the contributions of each level of the Organization. He proposed a minor amendment to the text proposed by the delegate of the United States of America.

Ms BENNETT (International Alliance of Patients' Organizations), speaking at the invitation of the CHAIRMAN, commended the Secretariat for developing a comprehensive draft programme of work that aimed to ensure the attainment by all peoples of the highest possible level of health. Noting that the management of noncommunicable diseases currently posed the greatest challenge to global health and would require an inclusive, cross-cutting approach, she said that a broader range of such diseases should be addressed in the draft general programme of work, so as to highlight their importance at the global level and thereby improve outcomes at the national level. The successful implementation of the draft programme of work required a focus on patient-centred health care and patient involvement. Her organization was committed to working with WHO in facilitating

engagement between all stakeholders, developing standards, guidelines and indicators for the implementation of patient-centred health care, collecting models of case studies and best practice, and identifying ways of measuring and monitoring effective global participation and engagement in health.

Mrs PARISOTTO (Medicus Mundi International – International Organisation for Cooperation in Health Care), speaking at the invitation of the CHAIRMAN, said that a flexible financing mechanism was essential to ensure that the Organization's priorities were successfully implemented. She noted, however, that the proposed financing dialogue would not prevent donor interests from distorting resource allocation, which meant that important areas of WHO's work that did not attract donor funding would continue to be starved of funds. The results chain framework had not been coherently developed and several outcomes and indicators were not matched by robust plans for intervention. The impact goals did not represent the breadth of WHO's work, and the impact targets and outcome targets were arbitrary, often unrealistic and did not take account of the external forces that influenced outcomes. At the same time, several targets should be more ambitious, such as those relating to health systems, information and evidence, and the social determinants of health. She urged Member States to address the core problems of the freeze on assessed contributions and the disproportionate influence of donors in setting the priorities of WHO's work.

Dr JAMA (Assistant Director-General) thanked the delegates for their comments, their participation in the development of the draft twelfth general programme of work and their broad support for the document. Further work on a robust monitoring and evaluation framework would be undertaken by the Secretariat and the results thereof would be presented at the November 2013 meeting on the financing dialogue. The amendments proposed by the delegate of the United States of America would be read out by the Secretariat for consideration by Member States. He apologized for the omission of the amendments proposed by the delegation of China from document A66/52 and confirmed that the following language would be included in the proposed amendments to the draft twelfth general programme of work: "One Member State suggested that the zero nominal growth of the assessed contributions should not continue, and that a small but sustained increase of assessed contributions needs to be considered in order to contain the trend of a growing imbalance of the WHO budget structure." Referring to the comments made by the delegate of Congo regarding the reduction in the level of funding for communicable diseases, he explained that the decrease concerned only the resources allocated to the Special Programme for Research and Training in Tropical Diseases, and did not affect the overall budget to tackle communicable diseases. The Secretariat would continue to work in a strategic and targeted manner to provide additional support to Member States in collaboration with its partners, such as the Global Fund to Fight AIDS, Tuberculosis and Malaria and the United States President's Emergency Plan for AIDS Relief and through, for example, implementation of the WHO roadmap for accelerating work to overcome the global impact of neglected tropical diseases (document WHO/HTM/NTD/2012.1).

Dr ARMSTRONG (Secretary) read out the amendment proposed by the delegation of the United States of America.

Mr SVERSUT (Brazil) said that the amendments to the draft twelfth general programme of work proposed by the delegation of the United States of America should be added to those set out in the Annex to document A66/52.

The CHAIRMAN said that he took it that the Committee agreed to that proposal.

**It was so agreed.**

The CHAIRMAN said that he took it that the Committee wished to approve the draft resolution, as amended by the Programme, Budget and Administration Committee in document A66/52.

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

**Proposed programme budget 2014–2015:** Item 12.3 of the Agenda (Documents A66/7, A66/7 Add.1 and A66/53)

Dr THABET NASHER (Yemen), speaking in his capacity as Chairman of the Programme, Budget and Administration Committee, introduced the Committee's report contained in document A66/53. The Committee recommended, on behalf of the Executive Board, that the Sixty-sixth World Health Assembly adopt the draft resolution contained in document A66/7 Add.1 and the draft decision contained in document A66/53.

Mr YOUSRY (Egypt), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that implementation of the WHO programme budget must be guided by the health priorities of Member States, taking into account the social, disease and environmental factors specific to each of them and with due regard for the WHO Constitution. Three core issues should be emphasized: the need for bottom-up planning with respect to the programme budget for the biennium 2016–2017; flexibility for Member States to determine their priorities under each budget item, as affirmed by the Regional Committee for the Eastern Mediterranean at its session in 2012; and the opportunity for WHO's governing bodies to express views concerning the distribution of budget allocations among regions and countries.

Ms GHEBRESELASIE (Norway) fully supported the proposal to approve the programme budget in its entirety. The financing dialogue represented an important step forward in the WHO reform process and should be used as a basis for open and informed discussion both on current priorities and on those for the coming biennium. More flexible funding would help to ensure that the agreed priorities in the programme budget were fully financed, and she encouraged Member States to indicate their possible level of flexibility. She underlined the need for strong coordination by the Secretariat during the period of targeted resource mobilization. The future financing of WHO would be a collective learning process, to be developed in response to the experience gained and lessons learnt; her country was ready to embark on that process. Although some of the details and issues related to the proposed programme budget required further clarification, that should not detract from the overall goal of making WHO a more democratic, transparent, reliable and capable organization. Some important elements, such as full costing and further refinement of the results chain, were missing from the proposed programme budget for 2014–2015 and should be included in the programme budget for the next biennium. Moreover, there was no obvious link between the leadership priorities in the draft twelfth general programme of work and the proposed programme budget, and that link should be made clear in future programme budgets. Future budget proposals should be based on a complete results chain, including a costing of outputs and the division of work within the Organization, thereby increasing accountability throughout WHO and allowing funds to be appropriately allocated. She would have welcomed the inclusion of information on the expected level of income, by type, to assist Member States in assessing the budget proposals.

Ms PATTERSON (Australia) expressed appreciation of the proposed programme budget 2014–2015 and commended the level of transparency already achieved by the Secretariat in the articulation of outputs, output indicators and key deliverables across the three levels of the Organization. Australia supported the budget allocations proposed for the six categories of work and for each programme area. Although it was essential that the programme budget clearly set out deliverables in terms of health and technical items, it was also important to include all expenditure when developing and financing the budget. In view of the need to ensure that WHO had adequate and

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



safe facilities both at headquarters and at the regional and country levels, her country had strongly supported the development of the Capital Master Plan and the sustainable financing mechanism. To prevent any recurrence of the regrettable current shortfall in funding under the mechanism for 2012–2013, she suggested that the Capital Master Plan be annexed to the proposed programme budget for 2014–2015 and that the real estate funding needs of the Organization be included in the financing dialogue; those two items should be more fully integrated into the programme budget in future bienniums.

Dr USHIO (Japan), welcoming the fact that the comments of Member States were reflected in the latest version of the proposed programme budget for 2014–2015, suggested that roles and responsibilities at the three levels of the Organization should be clearly differentiated in the final draft in order to improve efficiency and effectiveness; and he requested clarification from the Secretariat on the 30% increase in the proposed budget for preparedness, surveillance and response (Category 5), given that the draft twelfth general programme of work stated that the resource allocation to that category would remain stable.

Dr NGIRABEGA (Rwanda), speaking on behalf of the Member States of the African Region, expressed appreciation for the inclusion in the proposed programme budget for 2014–2015 of programming categories defined in the context of leadership priorities, as well as for the emphasis placed on poliomyelitis eradication, neglected tropical diseases, noncommunicable diseases and the strengthening of health systems. Noting with concern the decrease in the budget for communicable diseases, he urged WHO to maintain its strong leadership role in that area.

Despite the increase in the budget allocation to the Regional Office for Africa for the biennium 2014–2015, it was still lower than in 2008–2009 and 2010–2011. The programme budget was unbalanced because it relied heavily on voluntary contributions, and he urged Member States and partners to provide WHO with flexible funding. He hoped that the planned financing dialogue would lead to a transparent process in which the available resources matched the Organization's priorities.

He supported the adoption of the proposed programme budget for 2014–2015 in its entirety.

Ms JACOB (Ireland), speaking on behalf of the European Union and its Member States, supported the adoption of the proposed programme budget 2014–2015 in its entirety and endorsed the proposal to maintain funding from assessed contributions at the same level as in the current biennium. Recognizing that it was a transitional budget, the European Union recommended that country- and regional-level involvement in priority setting be enhanced for the programme budget 2016–2017, in order to build on programmatic reforms already implemented.

Regular and timely financial information on available income and funding gaps was crucial to the new approaches to WHO's financing and resource mobilization outlined in document A66/48. Accordingly and given the need to assess the results of those approaches over the coming two years, she suggested that the wording of paragraph 10 of the draft resolution contained in document A66/7 Add.1, after "implementation of the budget" should be amended to read: "as presented in document A66/7, including the outcome of the financing dialogue, the strategic allocation of flexible funding and the results of the coordinated resource mobilization strategy, through the Executive Board and its Programme, Budget and Administration Committee to the World Health Assembly, for review and endorsement".

She welcomed the Secretariat's commitment to measuring progress on the public health challenge posed by antimicrobial resistance over the next biennium and requested it to include more specific information at the outcome and output levels in the final draft of the proposed programme budget.

Ms BLACKWOOD (United States of America) supported the realistic programme budget presented in document A66/7 and the integrated budget process showing all sources of income. Despite being transitional, the budget should serve as an instrument for accountability and

transparency in programme implementation, results achieved, financing and resource mobilization; and the results chain would be essential for ensuring accountability at every level of the Organization. Noting that the results of WHO's work were not adequately captured in current reporting instruments, she stressed the need for future budgets to be fully costed so that Member States could see where and how funds were being spent. Transparency was also essential to the process of voluntary resource allocation to regional offices, especially in the light of the low level of allocation to the Regional Office for the Americas.

Noting that interim targets were being set for 2015 and 2020 as part of the global monitoring framework for the prevention and control of noncommunicable diseases, she requested that the wording of the eight outcome indicators for noncommunicable diseases be aligned with the wording of the indicators in the framework, in order to avoid inconsistencies. Pending their finalization, all the interim targets should be removed and replaced with the words "To be determined".

Mr BLAIS (Canada), endorsing the comments made by the previous speaker, supported the latest version of the proposed programme budget 2014–2015, whose structure and results chain were a clear improvement over previous bienniums. The final version should serve as a core tool for performance assessment, financing and resource mobilization. Canada also supported the establishment of funding ceilings for the programme and priority-setting categories, with the exception of Category 5 (Preparedness, surveillance and response) where greater flexibility was required for emergency risk and crisis management.

Noting that Member States were being asked to approve the budget in its entirety, he drew attention to the fact that that would create a collective – as opposed to an individual – obligation to raise the necessary funding. It would require Member States to recognize the importance of voluntary contributions to the Organization and be willing to take responsibility for its financing. The emphasis placed recently on cross-subsidization in relation to the use of assessed contributions to support voluntary programmes whose costs could not be covered by service charges alone had understandably generated some concern. However, there were other possible ways in which cross-subsidization could play a part in financing WHO. It was a subject that could be discussed in the planned financing dialogue, whose effectiveness would depend on a clear understanding of the use of assessed contributions to finance the Organization's core management and administrative functions. Canada wanted a larger share of those contributions to be allocated to fixed costs and suggested a gradual shift toward option D of the administration and management cost study presented in the Annex to document EBPBAC18/3.

Dr GWAK Jin (Republic of Korea) welcomed the substantial increase in budget allocations for categories 2 (Noncommunicable diseases), 3 (Promoting health through the life course) and 4 (Health systems) in the proposed programme budget for 2014–2015. Noting the importance of avoiding duplication through closer internal collaboration between departments and clusters, he announced his Government's decision to make a US\$ 1 million annual contribution to work under Category 4 over the following five years.

Ms HERNÁNDEZ NARVÁEZ (Mexico) supported the proposed programme budget 2014–2015 in its entirety and took note of the recommendations contained in the report of the Programme, Budget and Administration Committee of the Executive Board, in particular the recommendation concerning the adoption of a draft decision by the Health Assembly.

Mr KÜMMEL (Germany) noted the significant progress made in preparing the proposed programme budget for 2014–2015 and the draft twelfth general programme of work. However, neither document provided sufficient guidance on the critical subject of priority setting and on what actions could be undertaken in a situation hampered by resource constraints. Unless more was done to clarify WHO's core functions and the specific added value that it had to offer to the growing number of actors

in the global health arena, the Organization would have difficulty defining and protecting its role in that arena.

The proposed programme budget for the next biennium was a transitional budget and, hence, was not perfect. Clear improvements must be made over the coming two years to ensure that the next budget provided a transparent picture of the funding required to enable WHO's many programmes to achieve their expected outputs, thereby serving to strengthen the results-based management framework. Echoing the view expressed by the Independent Expert Oversight Advisory Committee in its annual report (Annex to document EBPBAC18/4, paragraph 12), he said that the programme budget, if it were to contain more information, would have greater potential to serve as an effective control over the operations of the Organization.

Dr AL KALBANI (Oman) expressed appreciation for the fact that the proposed programme budget under review was the first to provide an overview of all the resources needed to support it, thereby affording Member States an opportunity to adopt and oversee the budget in its entirety. It reflected the efforts made to date to improve the Organization's transparency, accountability, programming and financing. However, further details were needed on the costing of outputs and the establishment of a more robust monitoring and evaluation framework. Expressing the hope that the proposed programme budget for 2016–2017 would incorporate such improvements, he said that Oman supported the adoption of the draft resolution contained in document A66/7 Add.1.

Dr USORO (Nigeria) supported the proposed programme budget for 2014–2015 but called on WHO to ensure an improvement over the current biennium in terms of implementation. Nigeria was concerned about the lack of indicators or targets for haemoglobinopathies in the global monitoring framework and wished to see an increase in budget allocations for tackling noncommunicable diseases. It was furthermore concerned about earmarked funding and urged donors to show greater flexibility in order to support programme implementation and to avoid any bias in priority setting.

He expressed appreciation to the Republic of Korea for its pledge to contribute additional funding to health system strengthening.

Dr HARVEY (United Kingdom of Great Britain and Northern Ireland) welcomed the latest version of the proposed programme budget and the clear results chain linked to the draft twelfth general programme of work, which clarified the impact of WHO's work at the global, regional and country levels. She supported its adoption on the understanding that work would continue to develop a transparent resource allocation process; to provide more information on funding and funding gaps with respect to agreed priorities; and to finalize the reporting and monitoring framework so as to enable Member States to see the improvements made as a result of their spending. Lastly, management and administration costs should be considered separately so as to make it easier to determine how funds were being used, whether allocations were realistic and whether savings were being made. WHO had to improve the way in which it evaluated management and administration quality and to develop a savings strategy, with measurable targets.

Mr HAZIM (Morocco) commended the Secretariat's efforts, when preparing the current proposed programme budget, to take into account Member States' views regarding in particular the simplification and analysis of resource allocation to the six categories and to regional offices. Notwithstanding the increase in funding for noncommunicable diseases, the level of resources in the proposed programme budget for 2014–2015 remained low. A significant proportion of the funding to be allocated during the planned financing dialogue should go towards those diseases, especially in view of their prominent place in the post-2015 development agenda. Other concerns included the fact that the allocation to the Regional Office for the Eastern Mediterranean for 2014–2015 was only 1.1% higher than in the current biennium, and that the budget was distributed among 25 programme areas without taking into account Category 6 (Corporate services/enabling functions). He therefore recommended that the regional offices, working on the basis of accurate and objective criteria, should

seek to achieve an optimum budget distribution by country so that a budget could be set for a number of priority programme areas, taking into account the specificity of each individual country. Each country would then be working on fewer programmes and the method for assessing the outcomes would be improved.

Dr GOMEZ (Bahamas) commended the Secretariat's responsiveness to the many requests of Member States in preparing the proposed programme budget for 2014–2015, supported the amendments proposed by the delegate of the United States of America and urged the Director-General to give greater attention to the financing of the Capital Master Plan; safety and security were paramount and lessons must be learnt from the mistakes of others.

She approved the draft resolution contained in document A66/7 Add.1. Noting the flexibility that it gave the Director-General to make budget transfers between the six categories in the proposed programme budget, she said that she looked forward to learning more from the financing dialogue on the outcomes of that flexibility.

Mr EMANUELE (Ecuador), speaking on behalf of the Union of South American Nations, drew attention to the proposed budget allocation to the Region of the Americas and recalled resolution CE152.SS.R1 on allocation of funds by WHO to the Region of the Americas, adopted by the Pan American Health Organization at the special session of the 152nd session of the Executive Committee. Highlighting the importance of the strategic resource allocation model and its associated validation mechanism used since the biennium 2006–2007, he expressed concern about the systematic non-compliance over the previous three bienniums with the stipulation, under the terms of the mechanism, that an average 7% of the programme budget be allocated to the Region of the Americas. Given that the allocation in the proposed programme budget for 2014–2015 had only been increased to 4.4% from 4.2% in the current biennium, compared with 5.9% in the biennium 2008–2009 and 4.9% in the biennium 2010–2011, he requested clarification of the criteria used in preparing document A66/7. Unless the downward trend in the allocation was reversed, his Region was in danger of being unable to achieve the objectives of its programme of work. He therefore urged that a draft budget policy be presented to the Sixty-seventh World Health Assembly, with clear and equitable criteria for budget allocations to each regional office.

Dr DUONG ANH VUONG (Viet Nam), expressing appreciation for the latest version of the proposed programme budget, endorsed the decision to replace the 13 strategic objectives used in previous bienniums with six categories of work but favoured a greater focus in Category 4 (Health systems) on priorities such as health financing and health insurance coverage for developing countries. Noting that the proposed programme budget for 2014–2015 would be the first with a results-based management framework, which was sure to enhance the effectiveness of outputs, he said that the new approach should be piloted in priority categories before being applied across the board.

Dr RODRÍGUEZ (El Salvador) suggested that Category 2 of the proposed programme budget (Noncommunicable diseases) should include a focus on chronic renal disease, which added to the social and economic burden on many countries and regions. Furthermore, an emphasis should be placed in future programme budgets on priority forms of country cooperation.

El Salvador strongly supported the views expressed on behalf of the Member States of the Union of South American Nations with regard to the obvious unfairness of the budget allocation to the Region of the Americas, and to Latin America in particular.

Dr DE ROSAS-VALERA (Philippines) stressed the need for transparent and realistic budgeting, for alignment with national budgets and priorities, and for clear and detailed information indicating the outcomes of performance and results-based budgeting. She endorsed the suggestion made by the delegate of Viet Nam with regard to Category 4 and supported the statements by the delegates of Germany and the United Kingdom of Great Britain and Northern Ireland.

Mr SEN (Turkey) commended the efforts made by the Secretariat to reflect the comments of Member States in the latest version of the proposed programme budget, which was a key component of WHO reform. His delegation had been pleased to note that it included expected outputs and deliverables at all three levels of the Organization and resource allocations to major offices in each programme area. Although output targets and indicators were defined globally, future reports should provide further information on how they were linked to the work at each of the three levels, which would require an assessment of the performance and needs at each level. Furthermore, while the priority given to reform-related initiatives and the emphasis on accountability and risk management were much appreciated, the Secretariat should break down the figures to show the specific amounts of funding allocated and the efficiency savings expected from each initiative. Lastly, the success of the proposed programme budget depended on the necessary financial resources being secured through the financing dialogue. Further information would therefore be required on financing dialogue meetings, on the interim process between meetings and on the role of the governing bodies, whose legitimacy and primacy must not be undermined.

Mr SVERSUT (Brazil), referring to the strategic resource allocation model, said that the proposed programme budget for 2014–2015 would play a key role in ensuring more realistic resource allocation and enhancing the Organization's transparency and accountability. Brazil was concerned, however, that voluntary contributions would account for 77% of the total budget for the biennium and hoped that innovative mechanisms, such as the financing dialogue, would provide a lasting solution to the problem. He furthermore joined previous speakers in voicing concern about the continued decline in the budget allocated to the Region of the Americas and reiterated the importance of the strategic resource allocation validation mechanism. Latin America might have made significant progress in tackling health challenges and inequities, but countries in the Region needed to improve their policy-making in order to help especially the most vulnerable members of their population.

Ms POLACH (Argentina) strongly supported the points made by the delegate of Ecuador with regard to the resources allocated to the Region of the Americas and the proposal that a draft budget policy be presented to the Sixty-seventh World Health Assembly. She furthermore endorsed the draft decision contained in document A66/53, requesting the Director-General to propose a new strategic resource allocation methodology in WHO, starting with the programme budget for 2016–2017.

The DIRECTOR-GENERAL thanked the various speakers for their rich comments on the proposed programme budget 2014–2015, which reflected the robust and constructive engagement in the WHO reform process over the previous two years. That was, in the words of the delegate of Norway, a learning process both for the Secretariat and for Member States. She also thanked the Republic of Korea for its pledge of a US\$ 1 million annual contribution to health system strengthening over the coming five years.

Responding to the request for clarification from Japan on the apparent discrepancy between the proposed programme budget for 2014–2015 and the draft twelfth general programme of work, she said that the latter provided the vision for the Organization's work over the coming six years and that she had proposed a stable budget for that period amounting to a total budget envelope of around US\$ 12 billion, or US\$ 4 billion per biennium. That was because the Health Assembly had previously requested her, as chief executive officer, to prepare an accurate projection of income and expenditure. The Organization's income over the previous four years had remained stable within the range of US\$ 3.7 billion to US\$ 3.9 billion per biennium. In the area of expenditure, the Organization had been unable to implement a US\$ 4 billion budget every two years. She had therefore worked closely with regional directors and assistant directors-general on the proposed programme budget for 2014–2015, asking them to apply to the agreed six categories of work the priority-setting criteria that she had received over the previous two years from, among others, the intergovernmental working group. The first draft had been rejected because every single region, programme and office had asked for more resources and, while the easier option would have been to accede to their requests, she had chosen to

exercise budgetary discipline so as to ensure that the Organization lived within a realistic budget, as instructed by the Member States.

The most difficult task, as had been indicated by the delegate of Germany, was to identify what needed to be done to achieve the Organization's objectives in a context of bottom-up planning, especially at the country level. She therefore urged Member States to strive for a degree of behavioural change. Some countries, such as Brazil, India and many countries in Africa, were already using their own funds to implement their country programmes. Health care provision was ultimately their responsibility and, bearing in mind that WHO was a technical agency rather than a funding agency, she requested guidance from them as to how its limited resources could be used to support them in meeting their main demands. WHO could provide support for only the most important activities at country level, which should be carefully selected in order to maximize their chances of success. That meant that governments should discontinue the practice of breaking WHO country budgets down into smaller amounts for activities such as organizing a meeting or drafting a guideline. Her Regional Directors and Assistant Directors-General, during a staff retreat before the current Health Assembly, had committed themselves to change and she urged Member States to do likewise. Otherwise, if they continued to atomize their budgets, the full potential of the Organization's work would never be realized. Priority setting, therefore, was crucial, and should be guided by WHO's core functions and comparative advantage, avoiding any duplication of the work of sister agencies, within the framework of a stable budget of US\$ 4 billion for each of the next three bienniums.

The delegate of the United Kingdom of Great Britain and Northern Ireland had rightly pointed out that the Organization's management costs were currently mixed in with administrative costs. The Secretariat would therefore seek to clarify whether too much was being spent on bureaucracy instead of country programmes. She sensed overwhelming support for a fair and transparent resource allocation mechanism, to be implemented under governing body guidance. She agreed with the delegate of Germany that the proposed programme budget for the next biennium was a transitional budget and therefore far from perfect, inasmuch as the information it contained was incomplete. She therefore proposed that the programme budget for 2016–2017 should be prepared in accordance with a seven-step approach. First, the Secretariat would do its utmost to establish priorities by means of a bottom-up priority-setting process, based on input from Member States. Secondly, all outputs would be costed. Thirdly, the Secretariat would continue to improve the results chain, with a particular focus on clarifying the strategic linkage between the leadership priorities and the programme budget. Fourthly, it would incorporate the Capital Master Plan, as requested by several countries. Fifthly, it would develop a strategic dialogue and allocation mechanism for the fair distribution of resources, in response to the request for coordinated resource mobilization. The proposed programme budget was a core instrument for the achievement of transparency and accountability; it had to be linked to the financing dialogue and the allocation of the resources; and it had to guarantee results for every dollar received from Member States through headquarters or through regional or country offices. Those results had to be visible. Sixthly, greater emphasis would be placed on bottom-up planning, which was critical and which had not been dealt with properly in the current programme budget. Seventhly, the Secretariat would clearly tease out management and administrative costs, seeking guidance from Member States on how to finance them. She agreed with the delegate of Canada that a large proportion of assessed contributions should continue to be allocated to those costs, including the salaries of regional directors, WHO representatives at country level and core teams, in the current transitional phase. Those fixed costs were unavoidable. Thus, once the programme budget for 2014–2015 had been approved, most of the assessed contributions would continue to flow to the regional offices, to headquarters and to certain programmes in order to ensure that no core, strategic activity was left unfunded. If the financing dialogue proved to be successful and all voluntary contributions were aligned to priority programmes, there would be no risk of assessed contributions not being distributed. However, it would be an interactive process, requiring the leadership of the Member States with support from the Secretariat.

She appreciated having had the opportunity to share her thoughts with the broad membership of the Organization in a single gathering and hoped that her proposed way forward would meet with their approval.

The CHAIRMAN said that discussion of the item under consideration would be suspended until the next meeting.

(For continuation of the discussion and approval of the draft resolution and draft decision, see the summary record of the third meeting, section 2.)

**2. WHO REFORM:** Item 11 of the Agenda (Documents A66/48 and A66/50)

The CHAIRMAN invited the Committee to consider documents A66/48 and A66/50 on WHO reform: financing of WHO.

Dr THABET NASHER (Yemen), speaking in his capacity as Chairman of the Programme, Budget and Administration Committee of the Executive Board, introduced the Committee's report (document A66/50). The Committee, on behalf of the Executive Board, recommended that the Health Assembly note the report on the financing of WHO contained in document A66/48 and that it adopt the amended draft decision contained in document A66/50.

**The meeting rose at 11:50.**

### **THIRD MEETING**

**Tuesday, 21 May 2013, at 16:00**

**Chairman:** Dr W.T. GWENIGALE (Liberia)

#### **1. WHO REFORM:** Item 11 of the Agenda (Documents A66/48 and A66/50) (continued)

The CHAIRMAN invited the Committee to continue its discussion of the report on financing of WHO contained in document A66/48 and to consider the draft decision contained in document A66/50, after which he proposed to take up the draft resolution on the proposed programme budget 2014–2015 contained in document A66/7 Add.1 and the proposed amendments to the Financial Regulations and Financial Rules contained in documents A66/33 and A66/57, before turning to the discussion of the report on implementation of WHO reform contained in document A66/4.

Ms JACOB (Ireland), speaking on behalf of the European Union and its Member States, welcomed the proposed programme budget for 2014–2015 and was ready to support its adoption. She also supported the establishment of the proposed financing dialogue, which would ensure effectiveness and results, and guarantee the integrity of WHO's work through increased transparency, predictability, better budget alignment and joint accountability. She looked forward to an interactive, transparent dialogue.

The proposed amendment to Financial Regulation 5.1 as set out in document A66/33, with its recognition that Member States' legal obligations were limited to assessed contributions, was welcome. Since voluntary contributions were a significant source of funding for the Organization, the European Union fully supported efforts to raise the voluntary funding needed for the biennium 2014–2015 through the financing dialogue and a coordinated resource mobilization strategy. Flexible funding should be encouraged as a key means of improving the financing of WHO. She looked forward to proposals for incentivizing such funding as requested at the extraordinary meeting of the Programme, Budget and Administration Committee in December 2012.

The European Union welcomed the proposal for assessing the experiences of the first financing dialogue and the coordinated resource mobilization strategy prior to the commencement of the biennium 2016–2017, as outlined in document A66/48. There should then be a full assessment of the strategy during the second year of the financial cycle. The European Union looked forward to continued constructive engagement with WHO in achieving the shared objective of increasing the predictability and transparency of WHO's financing.

Dame Sally DAVIES (United Kingdom of Great Britain and Northern Ireland) said that reform was crucial in order to ensure that WHO could translate the resources collectively contributed by Member States into the maximum impact for people around the world, particularly those living in poverty. A sharper focus on agreed global health priorities would enable WHO to play its critical role as the lead global organization on health. She felt strongly that funding must be more closely aligned with agreed priorities and looked forward to participating in the new financing dialogue in order to achieve that aim. Any reform effort entailed difficult choices, and those who could remain focused on the bigger picture and embrace change were to be commended. That behaviour would earn the Organization international respect and strengthen WHO's leadership role. In a changing world, citizens expected more transparency and accountability, better financial management and better results from available resources. She saluted the reform efforts made by the Organization thus far and looked forward to further progress.



Dr MAHUGU (Kenya) observed that WHO's position as the overall directing and coordinating authority on international health work had been usurped by more robustly funded organizations. While he did not doubt their intentions or achievements, the multiplicity of global health actors had led to a lack of coordination in the field, fragmentation of health systems as a result of proliferation of initiatives, and duplication of activities and a lack of country ownership, especially in developing countries. Country ownership must be emphasized and resources must be channelled towards locally identified needs. Top-down approaches should be avoided.

WHO should refocus its core business on the health challenges facing countries in the twenty-first century. Reform of WHO's financing and management would enable the Organization to address those health challenges more effectively and avoid over-reliance on earmarked funding, which tended to be restricted to selected vertical programmes. He appealed to development partners to provide more flexible funding. Attention should also be paid to the market- and trade-driven interests of the international private, for-profit actors that, he affirmed, tended to dominate Health Assembly negotiations. The WHO reform process should result in securing WHO's position as the world's neutral and lead health organization.

Mr DEANE (Barbados) said that Barbados supported WHO reform as it would lead to improvement in the health status of populations and the advancement of health systems in Member States. Tackling the challenging task of reform would ensure that WHO could continue its leading role and enable the Organization to act as a broker between the many actors in international health. The world economic crisis had caused many in the health field to reflect on their mission, to reprioritize, and to strive to improve value for money. Those considerations had been at the centre of the reform initiative within the Organization. In order to ensure sustainability and harmonization of the reforms, they should be reflected at regional and country level and implemented in tandem with a robust continuous performance management system. Ensuring equitable distribution of resources among the regions was a matter of particular interest to the Member States of the Caribbean and to the Region of the Americas as a whole.

Dr KANITSORN SUMRIDDETHKAJORN (Thailand) commended WHO's commitment to improving the transparency and alignment of the Organization's financing. He particularly welcomed the proposed financing dialogue, an innovative mechanism that would increase the predictability and transparency of financing. He was optimistic that the mechanism would succeed in mobilizing the resources necessary for essential programme areas, especially those relating to human resources for health and the International Health Regulations (2005), and for the normative functions of WHO.

WHO's chronic underfunding would lead to ever-greater reliance on voluntary contributions, which were often earmarked, not only for programmes but also for countries and regions. His delegation therefore wished to propose a gradual increase in assessed contributions. The Programme, Budget and Administration Committee should explore the political feasibility of such an increase, which would gradually ensure the financial security of the Organization and the survival or resuscitation of essential activities and functions.

Mr MAMACOS (United States of America) expressed strong support for the proposed financing dialogue, which he saw as a critical step in the process of putting WHO on a more sustainable financial footing. As a significant donor, his Government recognized its responsibility in helping to ensure the dialogue's success and was committed to participating actively in the proposed first meeting and to providing full and transparent information on its current and planned contributions. He understood the limitations on participation by some potential external donors, as work was still under way on a set of principles and policies for WHO engagement with non-State actors. However, recognizing the innovative nature of the dialogue, and the need to think creatively about resource mobilization, he encouraged the Organization to be as inclusive as possible throughout the process.

The results of the financing dialogue should be submitted to the Executive Board in January 2014, together with initial information from the Secretariat on the planned allocation of assessed and flexible voluntary contributions. To require reporting at an earlier stage could inadvertently reduce incentives for voluntary contributions. It would also be useful for the Secretariat to provide the Board with an update on the resource mobilization strategy for the biennium, together with its plan for closing any remaining funding gaps. It was to be hoped that the proposed resource mobilization strategy would incorporate more active involvement with a broader set of stakeholders, including some non-State actors.

Mr RAO (India) welcomed the proposal to establish a structured and transparent financing dialogue. Since the mechanism did not yet exist, it was hard to say how well it would work and whether it would ensure control over the availability of funds before the beginning of a biennium. It should, however, increase the predictability of resources. India strongly supported higher assessed contributions and more flexible voluntary contributions.

He looked forward to the outcome of the review of organizational design aimed at ensuring that structure followed function and moved WHO towards more effective matrix management across the Organization, which would be critical for effective implementation of the programme budget in the period 2014–2015. He was pleased to note that the recommendations arising from the United Nations Joint Inspection Unit review of management, administration and decentralization in WHO had been included in the reform implementation plan. His Government reiterated its commitment to WHO reform, a process to which it had contributed US\$ 50 000 in 2013.

Dr USHIO (Japan), acknowledging the steady progress made on each component of WHO reform, expressed particular appreciation for the headway made on management reform, notably with respect to the financing of WHO. He supported the idea of approving the entire programme budget, which would enhance Member States' commitment and ownership with respect to WHO's resource requirements. He also supported the establishment of a financing dialogue. While the first meeting would be an important way to obtain detailed information on the funding needs of WHO, the second meeting would be crucial for the success of the new undertaking. In order to achieve the objectives of the second meeting – namely, to increase the predictability and alignment of WHO's financing and to formulate an approach to redress funding shortfalls – thorough planning and preparation would be required, including the provision of information to Member States and to non-State contributors well in advance of the meeting.

Mr BLAIS (Canada) welcomed the proposed establishment of a financing dialogue. He supported continued human resources reform aimed at ensuring that WHO had the right people and competencies to meet the needs of Member States. WHO should move to a culture of evaluation and accountability that would hold managers accountable for delivering reform measures, a process that would necessitate organizational change, including a review of the competencies that managers required. That effort should be supported by training. Quality management should be encouraged by including management competencies in recruitment criteria and in training goals. Priority-setting had been significantly enhanced as a result of reform, as evidenced by the draft twelfth general programme of work and the proposed programme budget for 2014–2015. The next step would be to achieve better alignment of resources with priorities. To that end, funding ceilings for the categories should be established and core funding should be aligned with the core work of the Organization.

Governance was an area of reform that was lagging. The Secretariat had shown a willingness to change, but Member States had been reluctant: it was time to focus on that crucial area. Canada supported the development of clear strategies for engaging non-State actors, in particular the private sector and civil society. To be successful, such strategies must include approaches for engaging with those that did not have a voice because they were poor, sick or not represented through official channels.

Mr LI Mingzhu (China) agreed that there was a need to accelerate and strengthen governance reform, which was lagging behind programmatic and management reform. In the area of management there was a misalignment between staffing and funding, since current policies encouraged staff to seek long-term employment whereas the Organization's funding was largely for short-term projects. He sought an update on progress toward the development of a model for strategic workforce planning and career development that would distinguish long-term functions (for which predictable long-term funding would be required) from time-limited projects linked to short-term funding.

Ms HERNÁNDEZ NARVÁEZ (Mexico) expressed support for efforts to improve the predictability of WHO's financing. That would strengthen programme implementation, as well as transparency and accountability in the use of resources. The financing dialogue would assist in that process: it would strengthen budget oversight and execution and improve alignment between financial contributions and programme priorities, thus making the budget a resource planning and risk management tool. The modalities and method of implementation of the financing dialogue could be improved over time in the light of experience and any recommendations made by the Independent Expert Oversight Advisory Committee.

Dr AL KALBANI (Oman) said that priority-setting in global health was at the forefront of the reform process, as were alignment of resources with priorities and greater harmonization and improved coordination among global health organizations. He favoured adoption of the draft decision contained in document A66/48. Concerning the proposed changes to the Rules of Procedure of the Executive Board, a study of their legal implications should be conducted and its findings presented to the Executive Board at its 134th session in 2014. With regard to managerial reform, he applauded the recommendations set forth in annexes 2 and 3 of the report on the high-level implementation plan for reform (document A66/4).

Mr KÜMMEL (Germany) supported approval of the entire programme budget by the Health Assembly. He also strongly supported the establishment of a financing dialogue, although the role of the governing bodies must not be weakened as a result of the dialogue. The financing dialogue should be viewed as a joint learning exercise for Member States and the Secretariat, one that offered the potential to match voluntary funding to needs and to increase understanding of how WHO operated on the ground, thereby strengthening transparency concerning the Organization's activities. The dialogue would also make it possible to allocate flexible resources strategically on the basis of expected voluntary funding. The financing dialogue would only be successful, however, if there was a good understanding of the funding that had already been secured, including voluntary funding from the Organization's three largest donors, most of which was based on multi-year agreements that covered more than one biennium. It was the role of the governing bodies to review the outcome of the financing dialogue and the strategic allocation of flexible resources.

Dr IDRIS (Nigeria) expressed concern that funding constraints continued to undermine the ability of WHO to be the prime authority in coordinating and directing global health. His delegation welcomed the proposed financing dialogue and called on Member States to mobilize additional resources for the Organization, with emphasis on flexible and predictable funding.

Professor AZAD (Bangladesh) said that reform would help to shape WHO into a dynamic organization capable of leading health reform both before 2015 and in the context of the post-2015 development agenda. The guidelines set out in document A66/48 concerning the proposed financing dialogue suggested that assessed and voluntary contributions would be merged, which was a source of concern. While he appreciated that the purpose of the merger was to ensure accountability and closer oversight of voluntary contributions by the Health Assembly, he was uncertain about its implications for the flow of funds to Member States. He noted that, although the South-East Asia Region had the

highest proportion of population with unmet health needs, it expected to see a decrease in its budget allocation in the biennium 2014–2015. Since financing reforms were being introduced in order to improve transparency in the allocation of funds, clear policies and guidelines should be established to ensure that the certainty of funding to regions and countries in need would not be compromised in any way as a result of the future financing dialogue.

Mr GRIFFITHS (World Vision International), speaking at the invitation of the CHAIRMAN, said that the present unbalanced funding arrangement had a significant impact on WHO's ability to oversee global health governance. The draft twelfth general programme of work outlined clear priorities which, if aligned with donor funding, would help to deal with reform challenges. However, care must be taken to prevent funders' priorities from shaping WHO's agenda; that would require an increase in the proportion of core and flexible funding that the Organization received. Ensuring that projects were aligned with legitimate WHO priorities should be a prerequisite for accepting non-State funding. Transparency, accountability and credibility of the non-State actors concerned were the key, as was an environment that fostered effective engagement and dialogue. An inclusive, representative forum would help to manage the risks associated with accepting funding from non-State actors and ensure that vested interests were balanced. WHO's engagement with non-State actors at country level should seek to enhance States' accountability to their populations without undermining their sovereignty, a process that would require the development of critical skills, especially among country office staff.

Ms FABBRI (Medicus Mundi International – International Organisation for Cooperation in Health Care), speaking at the invitation of the CHAIRMAN, expressed scepticism that the proposed financing dialogue, which would in essence be a pledging conference, would enhance the alignment of resources with outputs agreed by Member States, since it was doubtful that donors would support programmes that they had not supported in the past. Moreover, the power of donors to shape WHO's agenda would in no degree be reduced by the proposed arrangements, despite claims regarding enhanced transparency. The proposed dialogue presumed a continued freeze on assessed contributions, although that was one of the fundamental causes of WHO's current financial difficulties. She urged Member States to implement a substantial increase in assessed contributions as proposed during the extraordinary meeting of the Programme, Budget and Administration Committee in December 2012.

The Secretariat had put forward several initiatives aimed at promoting a more flexible workforce; however, one of those initiatives, the extension of the continuous service requirement from five years to 10 years, would clearly have a prejudicial impact on the gender balance of the WHO staff because women were less likely to have continuous service records. The Secretariat had also articulated a commitment to strengthening technical and policy support to Member States, but the specific initiatives described in document A66/4 were very weak. There were structural weaknesses in WHO's country-level engagement. Health development at the national level was in part a function of national politics, including the interplay of government and civil society. By cultivating a stronger relationship with civil society at the global and regional levels, WHO could contribute to a much richer engagement in health development at the national level.

Dr GUINTO (International Federation of Medical Students' Associations), speaking at the invitation of the CHAIRMAN and expressing appreciation for the efforts to improve WHO's engagement with non-State actors, said that meaningful youth participation was vital to effective global health governance and health development, as acknowledged in resolution WHA64.28. He urged the specific recognition of youth organizations in the overarching principles of WHO's engagement with non-State actors to be presented to the Executive Board at its 133rd session. His organization had been working to forge coalitions in order to promote greater youth participation. Before the Health Assembly, it had convened more than 40 young leaders to craft a unified youth voice on key agenda items affecting youth. The Organization should provide support for initiatives of that kind and create a formal space for youth engagement; Member States should include a youth

delegate in their Health Assembly delegations. Youth brought a unique and creative perspective, and its voice was essential to the future of global health and WHO.

He urged Member States to clarify WHO's policies with respect to relations with nongovernmental organizations, including procedures and criteria for involvement of those nongovernmental organizations with conflicts of interest. Financial or commercial interests must be fully disclosed and managed in decision-making processes.

Mr MALPANI (MSF International), speaking at the invitation of the CHAIRMAN, said that, in pursuing the reform agenda, Member States should ensure that they safeguarded WHO's core functions. He called on Member States and the Director-General to ensure that WHO continued to be the directing and coordinating authority on international health work and to strengthen and protect the Organization's ability to play that role throughout the reform process. The question of financing was the key to successful reform and must be kept at the centre of all reform-related discussions. Adequate, regular budget support must be secured for the core functions. Predictable and adequate financing would ensure that WHO could fulfil its mandate as the world's leading global health body, pursuing evidence-based policy that was free from outside pressure and conflicts of interest.

The DIRECTOR-GENERAL expressed appreciation for the guidance and broad support received from Member States and civil society representatives on WHO reform. The financing dialogue would be new for both Member States and the Secretariat, and it would be necessary for them to work together to make the process successful. She would meet with regional directors, WHO senior management and the Chairman of the Programme, Budget and Administration Committee in order to reflect on Member States' advice and expectations and prepare for the first meeting of the financing dialogue. The Secretariat would also continue to receive valuable guidance from the members of the Programme, Budget and Administration Committee and to work in cooperation with the Independent Expert Oversight Advisory Committee. She had taken due note of Member States' expectation that they would receive documents well in advance of the June and November 2013 financing dialogue meetings and that clear financial information would be provided to enable them to decide how they wished to invest in the Organization. A web portal would be set up for that purpose.

Member States had also raised various questions on the role of the governing bodies. Although the reform process would require changes in behaviour from both Member States and the Secretariat, the ultimate decision-making authority of the governing bodies would always be respected. She reiterated her commitment to provide regular updates to the governing bodies on income, expenditure and implementation and in turn to act on the guidance and decisions received from them. Member States and the Secretariat were embarking together on a positive process in which she stood ready to promote accountability and dialogue. She welcomed the atmosphere of high-level constructive engagement in which the dialogue had begun.

The CHAIRMAN said that, in the absence of any further comment, he would take it that Member States were ready to adopt the draft decision, as amended by the Programme, Budget and Administration Committee in document A66/50.

**The draft decision was approved.<sup>1</sup>**

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<sup>1</sup> Transmitted to the Health Assembly in the Committee's first report and adopted as decision WHA66(8).

## **2. PROGRAMME AND BUDGET MATTERS:** Item 12 of the Agenda (continued)

**Proposed programme budget 2014–2015:** Item 12.3 of the Agenda (Documents A66/7, A66/7 Add.1 and A66/53) (continued from the second meeting, section 1)

The CHAIRMAN drew attention to the draft resolution contained in document A66/7 Add.1, entitled “Programme budget 2014–2015”.

Dr ARMSTRONG (Secretary) said that a proposed amendment to paragraph 10 of the draft resolution had been submitted by Ireland on behalf of the European Union, whereby the words “as presented in document A66/7, including the outcome of the financing dialogue, the strategic allocation of flexible funding and the results of the coordinated resource mobilization strategy” would be inserted after “implementation of the budget” and the words “for review and endorsement” would be inserted after “World Health Assembly” at the end of the paragraph.

Ms PATTERSON (Australia) said that she understood and endorsed the rationale behind the proposed amendment but requested that the words “for review and endorsement” be struck from the end of the paragraph. It was sufficient, and in line with the standard approach taken in Health Assembly resolutions, simply to request the Director-General to report to the governing bodies. It was the responsibility of the governing bodies then to consider and review each report and to decide what, if any, action was required.

Ms BLACKWOOD (United States of America) agreed with the suggestion to remove the words “for review and endorsement” and further proposed that “including” be replaced with “and on” so as to make the intention of the paragraph clearer. Noting the potential burden on the Secretariat, she sought clarification on precisely which reports would be provided, when they would be provided and whether the European Union anticipated the provision of one report with three sections or three separate reports.

Dr TRIONO SOENDORO (Indonesia), speaking on behalf of the Member States of the South-East Asia Region, expressed concern about the proposed budget allocation to the Region for 2014–2015, which was US\$ 44 million, or 11.5%, lower than in the previous biennium. The Member States of the Region, in a spirit of global solidarity and mindful of the need to avoid major programme disruptions, sought clarification from the Director-General that there would be no abrupt reduction in the proportion of assessed contributions allocated to the South-East Asia Region and that programmes of key importance to the Region, particularly in the area of disease surveillance and response, would be safeguarded.

Dr WARIDA (Egypt), supported by Dr ERSHADI (Islamic Republic of Iran), expressing appreciation for the draft resolution, said that he looked forward to the full and transparent implementation of what was an excellent and realistic budget for the Organization. National implementation of the programmes and activities set out therein must, however, be consistent with the priorities of each State with respect to health, cultural, social, disease and environmental matters.

The DIRECTOR-GENERAL affirmed that the Secretariat would, to the extent possible with the resources available, align its work with country priorities; to that end, it was crucial for Member States to communicate their priorities. She pledged to do her utmost to work with all countries to mobilize the resources needed to fully fund the proposed programme budget. She would also work with the Chairman of the Programme, Budget and Administration Committee and with WHO’s staff to ensure that the allocation of resources across regions was fair and transparent and that the resources mobilized were used to produce results at country level.

Ms JACOB (Ireland) said that the aim of the amendment she had proposed was to facilitate the joint learning process between Secretariat and Member States to which the Director-General had alluded earlier. She welcomed the proposal by the delegate of the United States of America to substitute “and on” for “including”, as that wording would help to clarify the provisions of the paragraph. She was also comfortable with removing “for review and endorsement”, since such action was already part of the work of the governing bodies.

Mrs ESCOREL DE MORÃES (Brazil), recalling the earlier request for clarification on the criteria for allocating resources to the different regions, questioned whether the draft resolution, as amended, adequately reflected the fact that criteria would be developed and submitted through the Programme, Budget and Administration Committee for approval by Member States. The draft resolution should contain an explicit statement to that effect.

The DIRECTOR-GENERAL, responding to the delegate of Brazil, recalled that during the Programme, Budget and Administration Committee’s last meeting, the member for Mexico had raised the matter on behalf of the Member States of the Region of the Americas. It was important to understand that the programme budget for 2014–2015 would be a transitional budget. The aim was to incorporate into it all relevant principles and criteria. The Secretariat would work with the Programme, Budget and Administration Committee and would report back to the governing bodies once the criteria for strategic resource allocation had been formulated. If Member States agreed, the criteria would be implemented in the programme budget for 2016–2017.

Ms HERNÁNDEZ NARVÁEZ (Mexico) welcomed the clarification from the Director-General and affirmed that the matter had been discussed by the Programme, Budget and Administration Committee, which had decided to recommend to the Health Assembly that it approve a decision relating to the process outlined by the Director-General. The draft decision appeared in the Committee’s report, contained in document A66/53.

The CHAIRMAN took it that the Committee wished to approve the draft resolution contained in document A66/7 Add.1, as amended.

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

The CHAIRMAN drew attention to the draft decision contained in paragraph 13 of document A66/53 relating to the proposed programme budget for 2014–2015 and said that, in the absence of any objection, he would take it that the Committee wished to approve the draft decision.

**The draft decision was approved.<sup>2</sup>**

**Amendments to the Financial Regulations and Financial Rules:** Item 21.6 of the Agenda (Documents A66/33 and A66/57) (transferred from Committee B)

Dr THABET NASHER (Yemen), speaking in his capacity as Chairman of the Programme, Budget and Administration Committee, summarized the Committee’s report on the item, contained in document A66/57, noting in particular the amendments to the Financial Regulations and Financial Rules suggested by the Committee in addition to those proposed by the Director-General in document A66/33. The Committee, on behalf of the Executive Board, had recommended that the Health

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<sup>1</sup> Transmitted to the Health Assembly in the Committee’s first report and adopted as resolution WHA66.2.

<sup>2</sup> Transmitted to the Health Assembly in the Committee’s first report and adopted as decision WHA66(9).

Assembly should adopt the draft resolution contained in document A66/33, with the additional proposed amendments.

The CHAIRMAN said that in the absence of any comment, he would take it that the Committee wished to approve that draft resolution, including the amendments proposed by the Programme, Budget and Administration Committee.

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

**3. WHO REFORM:** Item 11 of the Agenda (Documents A66/4 and A66/49) (resumed)

Dr THABET NASHER (Yemen), speaking in his capacity as Chairman of the Programme, Budget and Administration Committee, summarized the report of the Committee on the item, contained in document A66/49, and said that the Committee had recommended that the Health Assembly note the report of the Director-General.

Mr PELLET (France) said that his Government shared the Director-General's ambition to modernize WHO and would follow with great interest the implementation of the reform decisions taken to date, particularly in relation to the Programme budget 2014–2015 and the Twelfth General Programme of Work, 2014–2019. The reform process would not be complete if three key outcomes were not achieved, the first being improved accountability at all levels of the Organization. Given WHO's decentralized nature, the success of reform would be measured on the basis of positive changes in regional and country offices, in particular enhanced accountability and transparency in WHO's activities on the ground. The second essential outcome of reform was a successful financing dialogue leading to tangible results in terms of funding for the priority activities identified by Member States. The difficulties with regard to predictability and flexibility of funding would not disappear immediately, however, and a medium-term evaluation of the financing dialogue should therefore be carried out so that the methodology could be adjusted if necessary. Lastly, WHO needed a strong and differentiated framework for engaging with the various categories of non-State actors in a manner that preserved the Organization's credibility, independence and role as a global health leader and that protected it against conflicts of interest.

Mr HOLM (Sweden), speaking also on behalf of Denmark, Finland, Iceland and Norway, said that a complete and comprehensive implementation plan was essential to reform and to follow-up on progress made. The plan must be supported by sufficient financial and human resources. Any short-term increases in the budget to meet such needs should be viewed in the context of securing long-term savings and improvements, although short-term investments must also deliver results. Regarding human resources, the Nordic countries underscored the particular importance of implementing actions to support a flexible workforce, to streamline recruitment processes and to enhance performance management.

He asked whether any funding gaps remained in the budget for reform in the current biennium and requested more information about the cost of each reform step and the efficiency gains that would be generated by the various aspects of reform. It was unclear how the achievement of some of the key outputs of the reform process would be measured, and further development of the necessary indicators would therefore be useful. The work done to clarify the roles and functions of the three levels of the Organization was welcome, but more information on the timeline for concluding that work and for reporting back to the governing bodies would be appreciated.

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<sup>1</sup> Transmitted to the Health Assembly in the Committee's first report and adopted as resolution WHA66.3.



Ms PATTERSON (Australia), welcoming the progress made to date on reform, stressed the importance of maintaining momentum in order to ensure that all of the outputs scheduled for completion in 2013 were achieved. Australia supported the continued engagement of the Independent Expert Oversight Advisory Committee in the reform process and was pleased that the report contained in document A66/4 was cross-referenced with the recommendations of the United Nations Joint Inspection Unit. As the reform process continued, it would be essential to have mechanisms in place for ensuring that expected outcomes were achieved. The performance management and reporting indicators provided a useful framework, as did the reporting requirements in the Programme budget 2014–2015, but over time it might be useful to adjust the implementation report in order to strengthen the focus on outcomes arising from the reform measures. She was pleased to inform the Committee that Australia had pledged one million Swiss francs to support the reform process in 2013.

Dr KANITSORN SUMRIDDETHKAJORN (Thailand) said that the reform process was timely, given the Organization's need to maintain its relevance and integrity among an increasing number of global health actors. He supported the criteria set out for programmatic priority-setting under the Programme budget 2014–2015 but would have expected a somewhat larger allocation for noncommunicable diseases. Given the increasing burden of such diseases in both developing and developed countries and the many challenges associated with them, the increase from 6.7% of the overall budget in 2012–2013 to 8% in 2014–2015 might not be sufficient. More resources should be allocated to the noncommunicable disease category, and a clear, effective plan should be developed to strengthen the technical capacity of Member States to implement the action plan for the prevention and control of noncommunicable diseases 2013–2020.

With an increasingly constrained budget, the Secretariat's engagement with Member States, nongovernmental organizations and other key actors was salutary. The Organization's knowledge and credibility were its strengths and could be valuable tools for attracting donors to support its programmes. The many partnerships developed with and between other global health actors and donors had contributed to the achievement of health objectives, but it must be ensured that WHO retained its presence and leadership role in the global health community. Systematic reforms with regard to recruitment processes and resource mobilization were needed for that purpose. It was also crucial that reform activities were rigorously implemented not only at headquarters but in all regional and country offices.

Dr BEN MAMOUN (Morocco) said that the fundamental challenge at the current juncture was to implement reform in a timely and reasonable manner, taking into account the recommendations contained in annexes 2 and 3 of the report (document A66/4). Priority-setting, in particular, must be emphasized and efforts undertaken to ensure that health occupied an important place in the post-2015 development agenda. Stronger linkages should be established between headquarters and regional and country offices, as should a mechanism for assessing outcomes. Throughout the reform discussion, Member States had constantly emphasized their wish to strengthen WHO's political and technical roles, which would in turn enable it to play a forward-looking role in the field of global health.

Mr MAMACOS (United States of America) said that the reform implementation steps taken by Member States and the Secretariat would help WHO to modernize and to meet new expectations with regard to transparency and accountability. He welcomed the work already undertaken to improve human resources policies, including staff rotation, but agreed with the delegate of Canada and others on the need for continued improvements in the area of human resources management. The Secretariat should present additional analyses and recommendations in the coming months with a view to furthering such reforms at all levels of the Organization.

Ms SY (Senegal), speaking on behalf of the Member States of the African Region, welcomed the progress made so far in implementing reform at both global and regional levels. It was not clear, however, what had been done so far with regard to the key objective of strengthening country offices.

Recalling the constructive discussions of the Executive Board at its 132nd session, she said that the Region looked forward to receiving proposals from the Secretariat on various aspects of reform, particularly the streamlining of the work of the governing bodies. It would be important to maintain respect for the sovereign rights of all Member States and to preserve the role of the Health Assembly as the Organization's supreme decision-making body.

The high-level implementation plan was detailed and quantifiable and greatly facilitated Member States' monitoring of the action taken on reform decisions. She welcomed the inclusion of change management as an integral part of the reform process and commended the incorporation into the implementation plan of the recommendations of the independent evaluation and of the United Nations Joint Inspection Unit. The plan could be further improved, however, by including an additional column in the outputs tables, indicating the reasons for any delay in implementation.

Mr KÜMMEL (Germany), affirming his country's commitment to the long-term strengthening of WHO and its role as a global health policy coordinator, said that the Secretariat's efficiency must be boosted, in particular through appropriate structures at all levels for the management and quality assurance of its activities. Such structures were also needed in order to ensure that WHO could continue to compete with other, younger global health actors. Strengthening the Organization required more than purely internal management reforms, however; open discussions with other health actors were necessary.

The frequent meetings of the WHO Global Policy Group represented significant and positive steps towards improving coordination between headquarters and the regions, but the results of the Group's discussions needed to be communicated more clearly and widely throughout the Organization in order to ensure coherent action at all levels. Germany fully endorsed the Director-General's statement that improving performance in countries was at the core of reform and welcomed her commitment to ensuring full transparency in order to improve efficiency. Comprehensive information should be shared with the governing bodies about WHO's presence and effectiveness at the country level so that Member States could provide guidance.

Mr SEN (Turkey) said that the information in the report was well structured and would enhance Member States' understanding of the reform implementation process. He welcomed the inclusion of change management as a component of that process, as it was essential to the success of reform. There were, however, certain areas that should be refined further. More information was needed, for example, on potential risks associated with weaknesses in the Organization's institutional structure and on any corrective measures that might be taken. In future reports the Secretariat should provide further information on both external and internal risks and on expected mitigating actions for all risk areas. The inclusion of target dates for the achievement of outputs was valuable, but in some instances only the start date was given, without any information on the expected end date of the particular reform activity. The report should specify those dates or, if appropriate, indicate whether the activity was deemed to be open-ended, so as to avoid any confusion. Budgetary figures for reform outputs had been provided only for 2012–2013; figures should also be provided for 2014–2015 as many of the target dates fell in that biennium.

The financing of WHO was perhaps the most important aspect of the reform process, since without the necessary funds for implementation the reform process would not produce the desired results. Regular updates should be provided on the availability and allocation of resources, both in future implementation reports and on the dedicated WHO reform web site. Such a step would improve transparency within WHO and enable Member States to monitor progress and provide guidance when necessary.

Mr SVERSUT (Brazil) said that the implementation plan and report contributed greatly to transparency and accountability and clearly showed progress in the reform process to date. He supported the establishment of the financing dialogue, as sustainable funding was essential in securing WHO's role as the leading global health agency. The dialogue would be a learning process for both

Member States and the Secretariat but would hopefully ensure the necessary predictability in funding for priority activities and programmes. Brazil would follow with particular interest the decisions taken with regard to the participation of non-State actors in the financing dialogue and the formulation of policies to strengthen wider engagement with such actors.

Dr SMITH (Adviser to the Director-General) confirmed that the Secretariat would continue to improve the implementation report and plan and would in future include a stronger risk management framework, start and end dates for outputs, and strengthened indicators. The Secretariat would also endeavour to ensure that the report better captured the impact of reform at country level. He acknowledged the many comments made regarding human resources and the need to make that area a key focus of reform. Responding to the request from the delegate of China for an update on the new workforce model, he noted that the annual report on human resources, contained in document A66/36, provided examples of changes in the model, particularly with respect to contract reform, mobility and rotation. The Secretariat would post on the dedicated WHO reform web site the report of the taskforce established to resolve the lack of clarity on the roles and functions of each of the three levels of WHO. An update on the taskforce's work would also be provided at the sessions of the Programme, Budget and Administration Committee and Executive Board in January 2014.

With regard to funding for reform efforts, he expressed appreciation for Australia's very welcome contribution of one million Swiss francs. The overall reform budget for 2012–2013 was US\$ 17.8 million, of which US\$ 12.8 million was currently available, meaning there was still a funding gap of about US\$ 5 million. The budget for reform in the biennium 2014–2015 would be approximately US\$ 16 million.

**The Committee noted the report.**

**The meeting rose at 18:15.**

## **FOURTH MEETING**

**Wednesday, 22 May 2013, at 09:40**

**Chairman:** Dr W.T. GWENIGALE (Liberia)

**later:** Dr L.G. ROSS (Solomon Islands)

**later:** Dr W.T. GWENIGALE (Liberia)

### **1. FIRST REPORT OF COMMITTEE A (Document A66/63 (Draft))**

Dr ARMSTRONG (Secretary) read out the draft first report of Committee A.

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

### **2. 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)

Dr ROZITA HALINA TUN HUSSEIN (Malaysia) welcomed the draft comprehensive mental health action plan 2013–2020 and endorsed its six cross-cutting principles, as well as the proposed actions for reducing the global burden of mental disorders. The plan's global targets were acceptable, with the exception of global target 3.2 (10% reduction of suicide rates by 2020) because accurate surveillance data might be difficult to obtain and, depending on past trends, the target might not be achievable in all countries. In developing a surveillance framework, account should be taken of the mental health issues common to all Member States. Furthermore, interagency cooperation and standardized data collection methods were necessary to enable data to be compared across countries.

Professor SHIRALIYEV (Azerbaijan) said that mental disorders placed a significant burden on health systems and socioeconomic development. His country had made considerable progress in reducing that burden: for example, it was currently drawing up a comprehensive plan for the prevention and treatment of mental health disorders; it had adopted a national strategy pursuant to the Mental Health Declaration for Europe, adopted in 2005; and it had enacted legislation to protect the rights of people with mental disorders. Psychiatrists, psychologists and social workers at the country's first national mental health centre, which had opened its doors in 2012, worked in cooperation with family doctors in the areas of prevention, early warning and rehabilitation. The draft comprehensive action plan would be instrumental in consolidating efforts to provide greater assistance in the area of mental health.

Dr KOH (United States of America) welcomed the fact that the draft comprehensive action plan proposed to build the knowledge and skills of both general and specialized health workers and that it called for reducing disparities in access to services and decreasing stigmatization. Global target 3.2, which aimed for a 10% reduction in suicide rates by 2020, was more realistic than the earlier target of

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

20% and was consistent with his country's goal of saving 20 000 lives in five years. He suggested that, in Appendix 1 of document A66/10 Rev.1, under global target 3.2, the words "number of completed suicides per year" should be replaced by "number of suicide deaths per year" in order to avoid any implication that death by suicide was a "success". Overall, he supported the objectives, targets and actions set out in the draft plan.

Professor PRASAD (India) welcomed the draft comprehensive action plan, which represented the culmination of the work initiated by his country with the support of Switzerland and the United States of America.

Professor DATTA (Bangladesh) welcomed the draft comprehensive action plan. According to *The Lancet* series on the Global Burden of Disease Study 2010, mental, neurological and substance use disorders together accounted for 13% of the total global disease burden, a greater percentage than heart disease, stroke and cancer. It was recognized that autism spectrum disorder placed a growing burden on all nations. Because it was mentioned only once in the draft comprehensive action plan, autism might not receive the attention it deserved when implementation began. He therefore proposed that the words "in accordance with the definition mentioned in paragraph 5" should be inserted after the words "with mental disorders" in the last line of paragraph 21 of the draft comprehensive action plan (document A66/10 Rev.1, Annex).

Dr MARTINEZ DE CUELLAR (Paraguay) said that Paraguay had its own mental health policy for the period 2011–2013 that reflected some of the main elements in the draft comprehensive action plan, which her country fully endorsed and was committed to implementing. Special attention should be paid in the draft comprehensive action plan to the traditional role of women as informal carers, particularly in low-income countries, and the need to provide them with holistic health care in order to prevent the onset of mental disorders. With regard to the draft resolution contained in document A66/10 Rev.1, she proposed that the words "ensuring that sufficient domestic resources are available, especially in developing countries, to enable the actions described in the draft comprehensive mental health action plan 2013–2020 to be put into practice" should be inserted at the end of paragraph 2.

Dr KABANGE NUMBI MUKWAMPA (Democratic Republic of the Congo), speaking on behalf of the Member States of the African Region, welcomed the collaborative approach that had been used to draw up the draft comprehensive action plan and urged Member States to adopt it. The action plan represented a global response to the burden of morbidity caused by mental illness. However, financial resources remained inadequate and there was a dearth of suitable strategies, trained mental health workers, medicines for treating mental disorders and relevant statistical data. Reform of health leadership and a stronger commitment by decision-makers nationally and internationally were also needed in order to ensure that effective mental health policy and legislation were in place. Furthermore, the impact of the draft comprehensive action plan could be heightened by: linking it to the draft action plan for the prevention and control of noncommunicable diseases 2013–2020, thereby increasing the pool of financial resources; using a multisectoral approach involving the health, education, employment, housing and legal sectors; and incorporating a mental health dimension into the prevention and treatment of drug and alcohol abuse.

Dr ISHIKAWA (Japan), endorsing the draft comprehensive action plan and the draft resolution contained in document A66/10 Rev.1, said that, traditionally, insufficient attention had been paid to mental health, but the growing interest in noncommunicable diseases should lead to greater awareness of the impact of mental disorders. Implementation of the action plan would require more work, in particular with regard to monitoring of indicators, an area in which WHO should take the lead. The number of health facilities and human resources with the necessary skills must be increased and a comprehensive approach adopted if the needs of people with mental disorders were to be properly met.

Professor BAGGOLEY (Australia) commended the collaboration in the preparation of the draft comprehensive action plan and endorsed its objectives. Global target 2, a 20% increase in service coverage for severe mental disorders (the definition of which should be set out clearly), was particularly worthy of support but should not detract from the broader objective of ensuring that people with mild and moderate mental disorders had access to the right level, mix and quality of services. In general, he supported global target 3.2, a 10% reduction in suicide rates, but was concerned that suicide reduction targets that were made public might discourage accurate reporting of suicide, and that more efficient data collection might lead to short-term increases in reported suicide rates. Furthermore, in view of the complexity of suicide determinants, suicide rates were not a suitable measure of mental health system performance.

Ms GRØNVOLD (Norway), speaking on behalf of the five Nordic countries, Denmark, Finland, Iceland, Norway and Sweden, welcomed the increased interest in mental health and endorsed the draft comprehensive action plan, the implementation of which must be cost-effective and synergistic. The draft action plan should place greater emphasis on the promotion of mental health, the principal determinants of which were a sense of identity and meaning in life, feelings of competence, a sense of security, affiliation and belonging, and adequate social support, and which was undermined by poverty, conflict and the breakdown of family and society. Health inequalities and the social determinants of health merited attention, for which greater intersectoral cooperation was needed, and better understanding of trans-generational and life-course perspectives should be sought. Indicators to assess mental health in populations should include positive as well as negative measures in order to produce a comprehensive picture of mental health status, and the prevalence and incidence of mental disorders should be monitored. Action plans concerning various health issues should be considered in conjunction with one another.

Ms PRETTY MULTIHARTINA (Indonesia) endorsed the draft comprehensive action plan in general, but some of the targets would need to be adjusted at country level to match existing capacities. Countries with limited resources should use their existing budgets as efficiently as possible to set up mental health programmes, while continuing to seek new funding. Many developing countries lacked accurate mental health data, including on treatment gaps and suicide rates, and most needed support in carrying out the relevant research. Reliable data were a powerful tool for implementing mental health programmes and identifying service needs, as well as for tailoring policies to local needs and strengthening existing initiatives. Objective 2, which called for the provision of comprehensive mental health and social care services in community-based settings, was a worthy goal but should be adjusted to reflect national capacities and priorities, in particular in developing countries. Countries also needed to strengthen community-based mental health services before reducing the number of hospital beds available.

Ms BELL (Canada) endorsed the draft comprehensive action plan, in particular its overall aims, which were to draw attention to mental health issues, reduce stigmatization and discrimination and improve mental health outcomes, and its emphasis on a multisectoral approach to mental health. Setting global targets was an important first step in bringing about measurable change. Nevertheless, it should be recognized that Member States' capacities varied and that some targets, particularly global target 3.2 on reducing suicide rates, the proposed amendment to which she endorsed, might be difficult to meet. Canada would do its utmost to achieve the global targets by 2020 and was willing to cooperate with WHO on the development of a core set of indicators to measure progress towards them.

Dr LEI Zhenglong (China) expressed broad support for the draft comprehensive action plan but requested that greater emphasis be placed on several aspects: sharing information on legal systems and outcome assessments in connection with mental health; fostering academic and technical cooperation; increasing support for mental health professionals in developing countries, particularly through

training programmes; and pursuing advocacy and awareness-raising projects, in order to encourage countries to provide assistance to impoverished mental health patients and to adopt a multisectoral approach. China was currently drafting its own mental health action plan covering the period 2013–2020 and would be willing to work more closely with WHO in that area.

Dr ESCARTIN (Philippines) endorsed the draft comprehensive action plan because it provided a wide range of strategies to guide Member States in promoting mental health and preventing mental disorders, which included protecting the human rights of persons with mental disorders and empowering families, communities and health care providers.

Mrs HARDING-ROUSE (Trinidad and Tobago), endorsing the draft comprehensive action plan, said that mental health and wellness was one of her country's strategic priorities. To that end, it was drafting a national mental health policy and plan, taking steps to integrate mental health into primary care and strengthening its mental health data collection system. Mental health legislation was being updated to ensure that the human rights of persons with mental disorders were protected, in accordance with the United Nations Convention on the Rights of Persons with Disabilities.

The mental health of all citizens must be protected. She therefore proposed that the words "and protected" should be inserted after "promoted" in paragraph 20 of the draft comprehensive action plan. The plan should also cover mental health literacy and create linkages between health ministries and authorities responsible for medical education. Under objective 3, suicide prevention measures should be extended to include all age groups since the suicide rate was highest among the elderly. Under global target 3.1, the word "national" should be replaced by "large-scale", in order to enable low- and middle-income countries with limited budgets to implement large-scale rather than national programmes. The plan should also include objectives that established a link between mental health and noncommunicable diseases, especially since mental disorders were not specifically targeted by the Millennium Development Goals.

Dr SOUMOUK (Central African Republic) endorsed the draft comprehensive action plan. Of particular importance was the sixth cross-cutting principle, which concerned the empowerment of persons with mental disorders and psychosocial disabilities. Although not explicitly stated in the action plan, one of the key dimensions of empowerment was social reintegration, given that victims of mental disorders suffered various social consequences, ranging from stigmatization to abandonment by family and society. Special attention should therefore be accorded to that dimension.

Mr PARK Chang-kyu (Republic of Korea) welcomed the draft comprehensive action plan, particularly since the incidence of suicide and mental vulnerability was high in his country. The Government had established mental health as a priority and was shifting its focus, not only in that area but for noncommunicable diseases in general, from treatment to prevention. It had established a comprehensive mental health plan the previous year and was working on revising its legislation in that field.

Dr AL-TAAE (Iraq) said that primary health care should cover all aspects of health care, including mental health. His Government was committed to tackling the problem of mental disorders through an integrated approach that included family planning and reproductive health services, and noncommunicable disease control initiatives. Its aim was to achieve the objectives set out in the draft comprehensive action plan, as well as the Millennium Development Goals. In view of the significant economic and social impact of mental illness, there was a need to link health services and social services in order to ensure the involvement of various sectors in the promotion of mental health.

Dr PAVIC SIMETIN (Croatia) strongly supported the draft comprehensive action plan, in particular its emphasis on the fundamental principles of universal access and equity, respect for human rights, evidence-based initiatives and best practices. The plan's multisectoral approach, its aim of

providing protection from mental disorder at all stages of the life cycle, and the empowerment of persons with mental disorders were equally welcome. She appreciated the fact that the actions proposed under the plan were clearly defined and partnerships at international, regional and national levels were encouraged.

Dr SEAKGOSING (Botswana) endorsed the draft comprehensive action plan. His Government would cooperate with WHO on its implementation. Mental disorders accounted for a significant proportion of all disabilities, and many people with severe mental disorders in low- and middle-income countries did not receive treatment. Recognizing the magnitude of the burden placed by mental illness on individuals, families and communities, his country had made strides in the areas of prevention and control, but more work was needed in order to enable people with mental disorders to lead productive lives. He supported the proposal by the delegate of Bangladesh to include the subject of autism in the draft plan and endorsed the idea of linking it with the draft action plan for the prevention and control of noncommunicable diseases.

Dr PITAKPOL BOONYAMALIK (Thailand), endorsing the draft comprehensive action plan, commended the cooperative efforts that had gone into its development. He particularly appreciated the plan's multisectoral approach, the clear guidance it provided in respect of the role to be played by the major partners involved, and the challenging targets it set for monitoring and evaluation. Nevertheless, the lack of a problem-oriented perspective within the action plan might result in misalignment between its objectives and indicators. Mental health problems must be prioritized, and activities involving promotion, prevention, health services and information systems should be coordinated during the planning phase, at all levels. The growing problem of childhood mental disorders called for separate plans and indicators devised specifically for children; in that connection, he welcomed the suggestion to place autism on the provisional agenda of the Executive Board at its 133rd session.

Ms TOELUPE (Samoa) welcomed the clear objectives and cross-cutting principles and approaches set out in the draft comprehensive action plan, which she endorsed as a whole. However, Member States would need support in carrying out the actions proposed in the plan and in achieving its objectives and targets.

Dr HO (Brunei Darussalam) supported the draft action plan, in particular the emphasis placed on policy and law, resource planning, stakeholder collaboration and empowerment. Her Government had been working to improve and expand its mental health services, in particular community-based services, with a view to providing integrated, multisectoral care with special sensitivity to cultural contexts. To that end it had drafted a national mental health plan and would shortly be implementing legislation related to education and training. She supported the call for increased mental health resources, which should be allocated to promotion and prevention, and welcomed the Secretariat's pledge to support Member States in developing information systems. Special mental health programmes should be designed not only for children and adolescents, as had been suggested by the delegate of Thailand, but also for pregnant women, mothers of young children and high-risk groups in the prison population.

Mr ÁLVAREZ LUCAS (Mexico), endorsing the draft comprehensive action plan, said that the main thrusts of the plan, and in particular its focus on human rights and the disabilities affecting mental health, were reflected in his country's national mental health policy, which accorded particular attention to promotion, prevention, treatment and rehabilitation, and access to community-based services. The draft action plan should include a psychosocial rehabilitation component specifically aimed at long-term psychiatric hospital patients who were especially vulnerable owing to physical or mental problems, abandonment by their family or inadequate access to social assistance.



Dr ALIMOV (Uzbekistan) welcomed the draft comprehensive action plan and said that his country would take the necessary steps to implement it. He endorsed the proposed draft resolution contained in document A66/10 Rev.1.

Dr AL-MARRI (Qatar), speaking on behalf of the Member States of the Eastern Mediterranean Region, commended the Secretariat's decision to hold broad consultations prior to drawing up the draft comprehensive action plan, which he fully endorsed. The promotion and protection of mental health were a vital social concern, as mental health was fundamental to leading a productive and enjoyable life. Specific concerns in the Region with regard to mental health included the stigmatization attached to mental disorders, political crises and their impact on the most vulnerable groups, the disturbingly high gap in low- and middle-income countries between treatment needs and the care available to people with severe mental disorders, and the high rate of suicide in people from 15 to 45 years of age. In that connection, he welcomed the fact that both the draft comprehensive action plan and the WHO Mental Health Gap Action Programme made reference to childhood mental disorders, including autism spectrum disorder.

Mr PETTERSON (Sweden) proposed that, in paragraph 2 of the draft resolution contained in document A66/10 Rev.1, the words "as adapted to national priorities and specific national circumstances" should be inserted after "2013–2020", and that, in the first line of that same paragraph, the words "proposed actions" should be replaced by "a menu of options". That would make the draft resolution more consistent with the draft action plan for the prevention and control of noncommunicable diseases 2013–2020.

Dr MBUGUA (Kenya) said that Kenya had participated in the preparation of the draft comprehensive action plan and was convinced that its targets and indicators would adequately address mental health issues. Her Government had implemented a comprehensive and integrated mental health policy and was drafting legislation in that area, but faced difficulties in providing adequate services owing to a scarcity of health facilities with mental health services, mental health workers, and adequate and affordable medicines. She called for the mobilization of additional resources to be allocated to mental health.

Mrs CHARLES-STIJNBERG (Suriname) said that suicide was a public health problem in many countries, including her own. Responsible reporting by the media, listed in the draft action plan as a suicide prevention measure, was difficult to put into practice. Despite briefings and information sessions, including distribution of WHO press kits, the media still tended to treat suicide sensationally, which only encouraged copycat behaviour, and she called on the Organization to identify innovative ways of fostering responsible reporting. Furthermore, it was important to limit access to highly toxic pesticides, and to use locally trained professionals to identify and manage suicidal behaviour in its early stages, as was being done in Suriname on a trial basis. Countries should exchange best practices in prevention, under the auspices of the Organization. Without technical support from WHO, the member countries of the Caribbean Community would not be able to meet by 2020 the targets set out in the draft action plan.

Dr RODRIGUEZ (El Salvador), endorsing the draft comprehensive action plan, said that despite numerous initiatives, including in the Region of the Americas, little progress had been made in integrating mental health into overall health care services. It was time to reverse that trend. Following a reform of its health care system, El Salvador accorded the same importance to mental health as it did to physical health with regard to promotion, prevention, treatment and rehabilitation, and those services were provided with the compassion to which all patients were entitled. It had also made efforts to ensure that mental health care was available at all levels: all specialized community health centres had a psychologist and almost all hospitals had mental health units. International cooperation had also played a crucial role in strengthening the national health service network.

Dr RAMOKGOPA (South Africa) welcomed the draft comprehensive action plan and expressed her gratitude to the Organization for providing technical support to her country in revising its national mental health policy and plan. She particularly appreciated the emphasis in the draft plan on collaboration and community-based mental health services. Reducing gender-based violence and abuse of women and children would play a major role in improving access to mental health services and in reducing comorbidity with many communicable and noncommunicable diseases, as well as injury and trauma. The targets set out in the draft plan were ambitious and many countries would need technical support in order to achieve them by 2020.

Dr SIMENDA (Zambia) said that the draft comprehensive action plan, which he endorsed, provided a consistent and coordinated approach to the treatment of mental disorders, and one that Member States would be able to implement. Its objectives and global targets were realistic and could be achieved by 2020. He called on stakeholders to assist grass-roots organizations in building their capacities, help them to fight the stigmatization and discrimination associated with mental disorders, and provide training in the production of evidence-based data.

Mr NEVES (Brazil) said that the draft comprehensive action plan, which would help to reinforce and guide national action, represented an important achievement by virtue of its emphasis on a coordinated multisectoral approach, vital for dealing with mental health issues. His country was moving towards using social integration and community care as ways of improving treatment and quality of life for individuals with mental disorders and, in that regard, he underlined the importance of incorporating social determinants of health and access to appropriate medications into national mental health policies. A political commitment to primary health care, support for community and family networks, and respect for human rights, produced much better results than the traditional psychiatric approach used in institutions.

Dr HONG SON CUNG (Viet Nam) welcomed the draft comprehensive action plan, which would guide his country in the preparation and adoption of its mental health legislation. He proposed that, after the fifth subparagraph under paragraph 23 of the draft action plan contained in the annex to document A66/10 Rev.1, the words “Integrated and community-based approach: Mental health and social care services need to be integrated into primary health care services and based on communities” should be inserted as a new subparagraph. He asked whether the terms “mental disorders” and “psychosocial disabilities” in paragraph 38 referred to different conditions. If that were the case, both terms should be defined in paragraph 5. He also asked whether specialized mental health hospitals were to be included in the service reorganization referred to in paragraph 56.

Dr ABDULRAHIM (Bahrain) supported adoption of the draft comprehensive action plan, which commendably took into account the views expressed by Member States at regional meetings or via the Internet. The Director-General was requested to provide support to Member States for national capacity-building, in the interest of putting in place the policies and measures necessary to ensure implementation of the plan at the regional level, improve research capabilities and develop monitoring systems for data collection.

Dr AFZAL (Pakistan), endorsing the draft comprehensive action plan, said that she welcomed the open dialogue that had taken place during its preparation. The increasing prevalence and incidence of mental disorders were contributing significantly to the disease burden, yet such disorders had failed to receive the attention they deserved. The draft action plan would help Member States to meet the challenges of tackling mental health issues, including setting up mechanisms to promote mental health, developing reliable data collection systems and implementing a multisectoral approach.

Dr COITINÑO (Uruguay) endorsed the vision, goals and principles of the draft comprehensive action plan. Uruguay had been working since 2011 to provide universal access to psychosocial

services and to psychotherapy in all its forms, both of which were regarded as fundamental to the prevention of mental disorders and suicide. Such services would also help to modify mental, physical and social behaviour and would benefit not only patients, but also their families and society in general. The implementation of the draft action plan, which had been inspired in part by national strategies, would be a significant step forward for mental health in the Region of the Americas.

Professor DELAFOSSE (Côte d'Ivoire) said that anthropological studies had demonstrated that, particularly in rural areas, attitudes towards death were shaped by the culture and suicide was not always acknowledged because it was regarded as shameful. In urban areas, it was important to recognize that adolescents engaged in suicidal behaviour, which was most often motivated by an identity crisis, as a way of defying death, rather than actually seeking it.

Mr SAMO (Federated States of Micronesia), associating himself with the statement made by the delegate of Samoa, endorsed the draft comprehensive action plan but was concerned that some of its proposed indicators might be too ambitious. He agreed with the emphasis in the action plan on preventive mental health services, treatment and access to essential psychotropic drugs.

Dr COOMBS (Jamaica), speaking on behalf of the member countries of the Caribbean Community, endorsed the draft comprehensive action plan and said that the countries of the Caribbean Community were in the process of drafting mental health legislation and developing mental health programmes in line with the plan. He was concerned, however, that the absence of baseline data and a scarcity of resources would make it difficult for many countries to achieve the global targets set out in the plan. The importance of a life-course approach could not be overstated: recognizing that many mental health problems began in early childhood and that mental health problems were prevalent among adolescents, the countries of the Caribbean Community were convinced that regional and global strategies aimed at strengthening parenting skills and meeting the needs of adolescents were required. Greater emphasis should therefore be placed on parenting under objective 3 of the draft plan.

Dr GOMEZ (Bahamas), welcoming the draft comprehensive action plan and the Organization's heightened focus on mental health, acknowledged the rise in the number of suicides worldwide, some of which had been assisted by technology. It was therefore important to monitor and manage websites that encouraged suicide and provided instructions on how to carry it out successfully. Agreeing with previous speakers that it would be difficult for the countries of the Caribbean Community to achieve the action plan targets, he suggested that a mid-term review of the targets should be included under the plan.

Mr RAHMONOV (Tajikistan) supported the draft comprehensive action plan and welcomed the important role played by WHO. His country, which had gone through a civil war, had made mental health a priority. It had put in place a national mental health strategy 2012–2016, as called for in the draft action plan, and was currently reviewing legislation on psychiatric services. As had been pointed out by the delegate of Canada, every country was at a different stage, and that fact should be taken into consideration when looking at indicators relating to national strategies and monitoring.

Mr DEANE (Barbados) welcomed the draft comprehensive action plan, and in particular its focus on universal health coverage and human rights and the shift towards community care, which should mitigate the loss of valuable human resources resulting from institutionalization. Society must change its perception of persons with mental disorders if they were to rejoin their community. In that regard, the failure of the draft action plan to focus on sustainable mental health education and promotion programmes was a source of concern, and funding should be allocated for that purpose. In addition, he suggested that an indicator for measuring the reduction in hospital beds should be included in the plan.

Ms CHUN-YING HUANG (Chinese Taipei) said that Chinese Taipei had promulgated a mental health act and had launched various mental health programmes. It had also increased significantly the number of psychiatric hospitals and community psychiatric services, the latter of which provided patient tracking and care, case management, medical assistance and referrals to other community resources. Under the mental health service network, each county had a community mental health centre that offered education and training, transition services, and suicide and substance abuse prevention. The year 2010 had marked the first time in 14 years that suicide was not among the top 10 causes of death in Chinese Taipei, and the suicide rate had continued to decline.

Ms FENU (CBM), speaking at the invitation of the CHAIRMAN, welcomed the focus on mental health by the current Health Assembly. The participatory approach used in preparing the draft comprehensive action plan, which had included a wide range of stakeholders, reflected the reality at country level where international and local nongovernmental organizations played a vital role in the provision of health care and social services. Their involvement with the Organization helped to ensure that its plans and programmes were “fit for purpose” and more likely to have a significant impact. She encouraged those affected by the activities under the action plan to participate actively in its implementation and monitoring.

Mr KARAMI-RUIZ (International Federation of Pharmaceutical Manufacturers and Associations), speaking at the invitation of the CHAIRMAN, commended the Secretariat’s vision and leadership in addressing the issue of mental health. Mental and neurological disorders often went unacknowledged yet placed a heavy burden on individuals, society and the economy, which must be reduced. Key tasks in that regard included overcoming external stigma and self-stigma, strengthening primary care services, and engaging government and other stakeholders in a multisectoral approach. The pharmaceutical industry was actively involved in the field of mental health: it was testing new compounds as well as helping patients on the ground. The International Federation itself had just launched a campaign to demonstrate the role that every stakeholder could play in mental health promotion. Innovative partnerships and new therapies were also needed, as was a renewed emphasis on brain research, to keep pace with the increasing disease burden of mental and neurological disorders.

Professor COPELAND (World Federation for Mental Health), speaking at the invitation of the CHAIRMAN and endorsing the draft comprehensive action plan, said that the plan closely reflected the views of civil society worldwide, and called on the Health Assembly to adopt and implement it. The recently published People’s Charter for Mental Health, drafted by the World Federation, was a civil society manifesto: it called on the United Nations to convene a special session of the General Assembly on mental health and to appoint a special envoy for mental health; urged that mental health be regarded as one of the top five noncommunicable diseases; and encouraged all countries to implement the WHO draft action plan.

Mr BESANÇON (International Pharmaceutical Federation), speaking at the invitation of the CHAIRMAN, said that, given WHO’s emphasis on integrating social services and mental health care into community care, Member States should include the pharmacy workforce in their human resources development policies in order to achieve the draft comprehensive action plan’s global target of increasing service coverage for severe mental disorders by 20%. The pharmaceutical industry had a proven track record in providing community-based mental health services, and his own organization was in the process of analysing the contribution of pharmacists to mental health and would produce a report on the subject in due course.

Dr LUCHESI (World Vision International), speaking at the invitation of the CHAIRMAN, said that mental disorders were a global health concern and could no longer be ignored. People with mental disorders experienced higher rates of disability and mortality, while suicide was the second most

common cause of death among young people worldwide. Mental, neurological and substance use disorders were on the rise. Mental disorders were linked to poverty, human rights abuses, social exclusion, and in some countries went untreated. The draft comprehensive action plan was ambitious and sought to ensure high quality, culturally appropriate health and social care. It offered civil society an opportunity to cooperate with countries in reaching a common goal.

Dr CORRALES DÍAZ (Costa Rica) proposed a series of amendments to the draft comprehensive action plan contained in the annex to document A66/10 Rev.1. In paragraph 28, Member States should be urged to strengthen inclusive social development processes. In paragraph 43, Member States should be encouraged to collaborate on national policy development with other sectors that had a direct impact on the country's economy, thereby ensuring that those social actors participated in the development of inclusive job definitions and inclusive job placement strategies. In paragraph 61, the Director-General should be asked to make Member States aware of the need to modify the traditional mental health care model and to inform them about the added value of decentralizing human and financial resources in order to strengthen primary health care services. Under global target 3.2, Member States should be encouraged to focus attention on suicide centres, with a view to measuring programme impact and determining the success rate of the activities undertaken.

Her country had only limited financial and human resources to allocate to implementation of the draft action plan. She therefore requested the Director-General to consider mobilizing resources for joint epidemiological research aimed at establishing baselines for mental and emotional disorders within populations, as well as to strengthen the leadership role played by health ministries.

Dr CHESTNOV (Assistant Director-General) commended Member States' willingness to lead the combat against mental disorders and welcomed their positive evaluation of the draft comprehensive action plan.

The burden of mental health disorders was increasing and Member States were taking adequate measures to reduce it. The draft plan was the first comprehensive mental health action plan to spell out the actions to be taken by Member States, stakeholders and the Secretariat; it was also the first plan to introduce a set of global targets for the promotion of mental well-being and the prevention and treatment of mental disorders. Adoption of the draft would be a landmark event, separating "before" from "after". Ignorance and complacency would thus be transformed into awareness and guided action.

Questions had been raised concerning the cost of the draft plan. The total cost for the eight-year period from 2013 to 2020 had been estimated at US\$ 97 million, of which US\$ 37 million was allocated to pay for staff and US\$ 60 million for activities. Additional funding from Member States, multilateral organizations and foundations would be needed to meet those costs, which would be discussed at the financing dialogues to be held in June and November 2013. He urged all countries to consider donating to that initiative.

Dr SAXENA (Mental Health and Substance Abuse) welcomed the strong support that had been expressed for the draft comprehensive action plan. As stated in paragraph 3 of the plan, it would be implemented together with other global and regional action plans, including the action plan of the global strategy for the prevention and control of noncommunicable diseases.

Autism and autism spectrum disorders merited attention and were definitely included in the draft action plan. Further guidance in that regard would be provided by the Executive Board at its 133rd session.

Responding to delegates' comments regarding the difficulty of attaining the proposed targets, he referred them to paragraphs 22 and 24 of the draft action plan, which specified the global nature of the targets. Member States could strive to reach those targets to the extent that was appropriate and feasible within specific national circumstances.

Dr ARMSTRONG (Secretary) indicated that the proposed amendments to the draft resolution contained in paragraph 6 of document A66/10 Rev.1 and to the draft action plan contained in the annex to that same document, would be reflected in a new document, which would be distributed as a conference paper.

The CHAIRMAN said that, if he heard no objections, he would take it that the Committee agreed.

**It was so agreed.**

(For continuation of the discussion and approval of the draft resolution, see the summary record of the eighth meeting, section 3.)

**Draft action plan for the prevention of avoidable blindness and visual impairment 2014–2019:** Item 13.4 of the Agenda (Documents A66/11, A66/11 Add.1 and EB132/2013/REC/1, resolution EB132.R1)

Dr ST. JOHN (Barbados, representative of the Executive Board) recalled that the Executive Board, at its 132nd session in January 2013, had considered a report by the Secretariat containing the draft action plan for the prevention of avoidable blindness and visual impairment 2014–2019. Fourteen members had taken the floor to comment on and support the draft action plan. Some had suggested specific actions that could be taken to strengthen the plan; others had requested the inclusion of indicators to measure eye care quality, and of references to trachoma and onchocerciasis elimination, as well as a greater focus on childhood blindness and rehabilitation. One had called for country- and region-specific targets and strategies to facilitate implementation. The Health Assembly was invited to adopt the draft resolution recommended by the Executive Board in resolution EB132.R1.

H.R.H. Prince ALSAUD (Saudi Arabia), speaking on behalf of the Member States of the Eastern Mediterranean Region, welcomed the draft action plan, which drew on research and built on the previous action plan. WHO had made major strides in the previous two decades: according to the most recent data, the number of persons with blindness had fallen from 45 million to 39 million. The draft action plan would serve as an incentive to provide support for programmes aimed at preventing blindness. However, the plan would have to be amended to take account of the current average age for blindness. Some countries in the Region had begun to draw up national plans in line with the proposed plan, for which he expressed support. He called on other States to adopt and implement the plan.

Dr HONG SON CUNG (Viet Nam) welcomed the draft action plan. His country was seeking to reduce its blindness rate in keeping with the global target of a 25% reduction by 2019. In Viet Nam, the prevalence of avoidable blindness in people over the age of 50 years had been determined by rapid assessment as being 3.1%, and the cataract surgery rate was 1900 per million population, which fell short of the minimum target of 2500 per million population. That rate was due to shortages in funding, equipment and surgeons in several remote provinces, and he called on WHO and other international agencies to provide the needed support. He endorsed the draft action plan's focus on cataracts and uncorrected refractive error, which were two of the principal causes of avoidable visual impairment, and on the global effort to eliminate trachoma. The incidence of trachoma had decreased significantly in certain areas of his country, but the nationwide trachoma survey was incomplete and the incidence of entropion remained a challenge.

Professor ELIRA-DOKEKIAS (Congo), speaking on behalf of the Member States of the African Region, endorsed the draft action plan. It was estimated that 27 million people in the Region were visually impaired, 6.8 million of whom were blind. Those figures were especially worrying in view of the emergence of noncommunicable diseases and the persistence of onchocerciasis in some

parts of the Region. A series of preventive and treatment measures had been suggested for the Region, but implementing them would be a major challenge. Such measures would minimize the risk of congenital ocular anomalies resulting from rubella, enable early detection of the principal risk factors for vascular damage and blindness, and ensure better treatment for patients. Particular attention should be paid to the prevention and treatment of cataracts, an avoidable cause of blindness; operation rates would be a good indicator for evaluating results in that area.

The Member States in the Region were committed to achieving the global target of reducing avoidable blindness and visual impairment by 25% by 2019. To do so, they had to reach various intermediate goals. First, some countries were in need of technical support with the proper use of national indicators. Secondly, medical staff capacities needed to be built and health systems and health care improved. Thirdly, universal access to preventive treatments must be ensured for all high-risk populations and access to treatment guaranteed for all those who were ill; and fourthly, national programmes must be implemented effectively. Combating blindness should be a joint effort on the part of governments and international organizations.

**Dr Ross took the Chair.**

Dr KENYON (United States of America), endorsed the draft action plan. He welcomed the efforts of the Secretariat and international partners to implement the current action plan for the prevention of avoidable blindness and visual impairment covering the period 2009–2013, and in particular, the activities to improve data collection and surveillance, expand research initiatives globally, advance multisectoral action and set global targets and national indicators. The draft action plan for 2014–2019 appeared on the Health Assembly's agenda under the category of noncommunicable diseases, since complications of such diseases could lead to blindness. At the same time, there was a critical link between avoidable blindness and communicable diseases, in particular neglected tropical diseases and cytomegalovirus retinitis. WHO must continue to encourage the provision of eye care that reflected the disease burdens of individual Member States and was fully integrated into health care systems.

Mr FERDINAN TARIGAN (Indonesia) supported the measures that had been taken to eliminate trachoma and welcomed the attention that had been paid to the problem by the international community. Indonesia had updated its national plan for the prevention of avoidable blindness and visual impairment in 2000, and had been conducting a national eye health survey. It had reduced the prevalence of blindness by at least 40% owing mainly to an annual increase in the number of cataract surgeries performed. However, the needs of the country's ageing population were giving rise to a backlog in cataract surgeries. Indonesia was pursuing its efforts to combat avoidable blindness and visual impairment and needed technical assistance and programme development support, in particular for programmes to provide affordable eye glasses to school-age children and the elderly with visual impairments.

Dr MULENGA (Zambia) fully supported the principles, objectives and measures set out in the draft action plan. The plan covered all the critical areas of eye health service delivery; it was also practical and realistic and amenable to implementation. Ownership of the draft action plan should be decentralized to the national, provincial, district and community levels, and it should be integrated into health systems by means of regional and national agreements. Governments and other stakeholders must provide more resources for research so that data on disease burdens, obstacles to eye health, and service provision and costs could be obtained. Greater emphasis should be placed on human resource development in the area of eye health.

Dr AMUNUGAMA (Sri Lanka), speaking on behalf of the Member States of the South-East Asia Region, said that the Region accounted for 28% of the global burden of avoidable blindness, caused mainly by cataract in adulthood and childhood visual impairment. Measures taken in the Region under the current action plan had focused on an integrated approach to blindness prevention at the primary health care level aimed at achieving sustainable eye care services. Many national initiatives to combat preventable blindness had been carried out, but it remained an important public health issue. He welcomed the draft action plan, which would serve as a guide for strengthening regional and country-level plans. To pursue its work on avoidable blindness, the Region would need technical and financial support from WHO and other donor agencies, in particular for the development of infrastructure, human resources, national and regional indicators, and monitoring systems.

Dr SINGH (India) endorsed the draft action plan and said that her country was already implementing activities relating to the three objectives set out in the plan, and would continue to do so. With regard to objective 1, it planned to conduct another rapid assessment survey for avoidable blindness; under objective 2, its national blindness control programme had been incorporated into the national rural health mission; and in respect of objective 3, the national Government was fostering partnerships among multiple stakeholders. India had sufficient resources to use the draft plan's three indicators for measuring progress at the national level.

Dr SADRIZADEH (Islamic Republic of Iran) endorsed the draft action plan and the proposed draft resolution. He emphasized the need to provide affordable cataract surgery to all those who were in need of it, and the importance of developing national strategies for the prevention of traumatic blindness due to car accidents, with an emphasis on the use of seatbelts and other appropriate measures. Such strategies should be integrated into comprehensive eye care services to ensure their affordability and cost-effectiveness.

Dr KAMALIAH MOHAMAD NOH (Malaysia), endorsing the draft action plan and the proposed draft resolution, said that avoidable blindness and visual impairment must remain a priority on the global public health agenda since they were expected to increase in parallel with socioeconomic development, which brought with it a longer life expectancy and a rise in noncommunicable diseases. The plan's three objectives covered all the elements needed to reduce the burden of avoidable visual impairment. She endorsed the global target of reducing the prevalence of avoidable visual impairment by 25% by 2019 as well as the three indicators set out in the draft plan, and her Government would be asking WHO for technical support in strengthening its surveillance systems in order to measure progress.

Dr AL-TAAE (Iraq) said that, in order to be successful, implementation of the joint global initiative VISION 2020 should be paralleled by the integration of primary eye care into primary health care. Primary eye care services should also be included under the Millennium Development Goals in general, and in the strategies for poverty alleviation and the control of communicable and noncommunicable diseases in particular. They should likewise be integrated into reproductive health services owing to the problem of child blindness, which accounted for 10% of all cases of blindness. Iraq had made significant progress on that score through early detection of congenital defects and by tackling nutrient deficiencies, notably of vitamin A. It had also worked to integrate eye care facilities into school health services and activities aimed at promoting health and building a healthy lifestyle. Indicators to measure implementation should be established, especially for cases of cataract, refractive errors and diabetic retinopathy, based on the system of family medicine and family health practices, in order to reduce the disease burden.



Dr AHMED (Bangladesh) said that his country had been implementing the VISION 2020 initiative and the action plan for the period 2009–2013, with the cooperation of the relevant stakeholders. The proposed draft action plan, which he endorsed, would enable Member States to finish any tasks left over from the previous plan in addition to taking on new ones and, in that regard, he recommended that priority be given to emerging causes of blindness, including age-related macular degeneration, diabetic and premature retinopathy, ocular trauma and refractive error. He supported the draft resolution.

Dr CHOMPOONUT THAICHINDA (Thailand) endorsed the draft action plan but found it inadequate on several fronts. First, universal eye care applied not only to coverage but also to access. The indicators to measure progress in that regard should therefore include disaggregated data to assess progress in reducing unequal access to basic services. Secondly, the number of eye care personnel did not necessarily indicate a higher level of care; a more relevant indicator would be the quality of eye care personnel. Unbalanced distribution of the workforce, as well as its capacity and performance, was also a concern. Allied ophthalmic personnel, including those working in primary health care, should be trained to work effectively in specialized areas in settings that were appropriate to the local context. Thirdly, new technologies and techniques had greatly increased the cost of eye health care, while many countries did not have the resources to make evidence-based decisions about what equipment was needed. The Secretariat could play an important role in strengthening Member States' capacity to assess technology, and reference to that role should be included in the draft action plan. Fourthly, in view of the life-long consequences of childhood blindness and low vision, the draft action plan should focus on early detection and treatment of reversible causes of blindness and visual impairment.

Dr CICOGLA (Italy) said that, despite recent progress in the control and prevention of avoidable blindness and visual impairment, poor and vulnerable populations still suffered inordinately from those disabilities. His country had implemented many WHO resolutions in the area of blindness and visual impairment; for example, it had set up a national committee, prepared national guidelines, and produced an inventory of its development cooperation activities in that field. In addition, his country's National Centre for the Prevention of Blindness had recently been designated as a WHO collaborating centre. He supported the draft action plan, welcoming in particular its emphasis on visual impairment and rehabilitation, and wished Italy to join the list of sponsors of the draft resolution.

Mr COTTERELL (Australia) said that avoidable visual impairment was an issue of great importance not only for health and social progress, but also for economic growth. His country favoured the adoption and implementation of the draft action plan and the associated draft resolution, in accordance with national priorities. Australia had recently allocated 40 million Australian dollars over four years to help developing countries in the Asia-Pacific region to meet the challenge of avoidable blindness. He endorsed the global target and three indicators set out in the draft action plan, but pointed out that cataract surgery coverage might be difficult to measure.

Mrs CARTER TAYLOR (Barbados), endorsing the draft action plan and the draft resolution, said that the elimination of avoidable blindness would greatly enhance the quality of life for millions of people worldwide. She applauded the emphasis in the plan on evidence-based planning and on universal access and equity, and she welcomed the targets and indicators that it had identified. Barbados had established a national task force whose terms of reference were to develop a national policy and strategy that was consistent with the draft action plan, which was regarded as critical to shaping her country's eye health policy.

Mr KOBAYASHI (Japan) said that avoidable blindness and visual impairment were not fatal but had a significant negative impact on quality of life. The draft action plan had an important role to play in mitigating the disease burden imposed by those conditions, and the strategic actions that it recommended should be developed further to ensure the feasibility of the plan. Blindness and visual impairment had multiple causes, which must be taken into account in formulating public health prevention and treatment strategies. The current rise in noncommunicable diseases could be expected to increase the incidence of cataracts and diabetic retinopathy. Prevention and treatment of those conditions, including advocacy and awareness-raising, should be an integral part of eye health strategies, with a close link to noncommunicable disease programmes. He endorsed the draft action plan and the draft resolution associated with it.

**Dr Gwenigale resumed the Chair.**

Dr ALZAYANI (Bahrain) said that Bahrain fully supported the draft plan and would endeavour to implement it.

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

## **FIFTH MEETING**

**Wednesday, 22 May 2013, at 14:30**

**Chairman:** Dr W.T. GWENIGALE (Liberia)

**later:** Dr L.G. ROSS (Solomon Islands)

**later:** Dr W.T. GWENIGALE (Liberia)

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

**Draft action plan for the prevention of avoidable blindness and visual impairment 2014–2019:**  
Item 13.4 of the Agenda (Documents A66/11, A66/11 Add.1 and EB132/2013/REC/1, resolution EB132.R1) (continued)

Mr TOSCANO VELASCO (Mexico) commended the draft action plan for the prevention of avoidable blindness and visual impairment 2014–2019, because it provided clear information on the number of people with visual impairment and the impact on development at both national and international levels. As a result of a lack of eye-care services, 120 million people experienced visual impairment from uncorrected refractive errors, placing an economic burden on countries through lost productivity and increased health care and social costs. According to WHO, 80% of cases of visual impairment could be avoided or cured. He welcomed the draft action plan, which was linked to universal access and in line with relevant national plans.

Ms JAMEEL (Maldives) supported the draft action plan and outlined several measures that had been introduced in Maldives, including an allowance for people with visual impairment and clinics in areas without ophthalmology services, provided by nongovernmental organizations with private sector support. She drew attention to the prevalence of ocular toxoplasmosis, particularly in the south of the country. Actions to prevent the spread of the condition required an integrated approach, including improving skill in early diagnosis and conducting prevalence surveys.

Mrs CHARLES-STIJNBERG (Suriname) said that the draft action plan provided guidance for working towards prevention of avoidable blindness and visual impairment. However, the financial aspects of objective 1 were a cause for concern and WHO might have to support countries in seeking financial assistance for carrying out population eye surveys. She drew attention to the need to integrate eye health screening in services dealing with chronic diseases, such as hypertension and diabetes, as it was crucial to detect and treat early-stage eye complications from those diseases. She called on WHO to support further development and implementation of the proper protocols, for example, expansion of chronic care “passports”. She endorsed the draft resolution.

Dr AFZAL (Pakistan) drew attention to the adverse impact of blindness on life expectancy and quality of life, with consequences such as lost productivity, financial insecurity and social isolation. She would welcome collaboration with WHO and its partner agencies in order to scale up Pakistan’s avoidable blindness programme. The draft action plan contained in document A66/11, which incorporated lessons learnt from the Action plan for the prevention of avoidable blindness and visual impairment 2009–2013, offered continuity and should stimulate the actions already being undertaken. She endorsed the draft resolution.

Ms Yu-Hsuan LIN (Chinese Taipei) commended the Secretariat's report and emphasized the importance of comprehensive and evidence-based eye health policies. Myopia was a major visual health problem in Chinese Taipei, Hong Kong Special Administrative Region (China), Singapore, and many other Asian countries. In Chinese Taipei, 22% and 70% of grade 1 and grade 6 students, respectively, had myopia, which could lead to serious loss of vision or blindness. Because effective preventive measures were not yet available, a prevention programme promoting outdoor activity was being trialled to ascertain whether myopia and visual deterioration in elementary schoolchildren could be prevented. In an ageing population, there was likely to be an increase in diabetic retinopathy, which could also cause blindness and should be treated as early as possible. The condition should be included in health promotion activities in order to sensitize the public to the link between diabetes and retinopathy. Chinese Taipei was eager to share its experiences in regional health promotion.

Dr CHESTNOV (Assistant Director-General) thanked the delegates for their comments, as well as their guidance in drafting the action plan. He assured the delegate of Zambia that his proposal on decentralizing ownership of the plan would be taken into consideration and included in the text. The facts and figures provided by Member States were helpful. Between 2004 and 2010, the number of people worldwide with visual impairment was estimated to have dropped from 314 million, of whom 45 million were blind, to 285 million, of whom 39 million were blind, corresponding to a reduction of about 10% in visual impairment globally. The next joint objective should be to focus on the 1.8 million people worldwide who had been irreversibly blinded by trachoma, as well as the estimated 20 million people who were blind as a result of cataracts, a condition that could be reversed through simple and effective surgery. Implementation of the draft action plan could prevent millions more cases of avoidable blindness.

The CHAIRMAN said that, in the absence of any comments, he took it that the Committee wished to approve the draft resolution contained in resolution EB132.R1.

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

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

Dr MOHAMED (Maldives, representative of the Executive Board) said that, at its 132nd session, the Executive Board had considered a report on the findings and recommendations of the *World report on disability* and had adopted resolution EB132.R5. The Health Assembly was invited to consider the draft resolution contained in resolution EB132.R5.

Professor DATTA (Bangladesh) commended the comprehensive report on disability and looked forward to the outcome of the High-level Meeting of the United Nations General Assembly on disability and development to be held on 23 September 2013. His Government regarded the prevention of disability as a priority and had devised a national strategic plan on the surveillance and prevention of disability covering the period 2011–2015. It was also striving to raise awareness about autism. Cases of autism spectrum disorder were increasing in all Member States; however, the nature of the condition had only recently been fully recognized and continued to pose grave problems, in particular for families and teachers. Further attention was being focused on autism as a result of United Nations General Assembly resolution 67/82 addressing the socioeconomic needs of individuals, families and societies affected by autism spectrum disorders, developmental disorders, and associated disabilities, and resolution SEA/RC65/R8 on comprehensive and coordinated efforts for the management of autism spectrum disorders and developmental disabilities adopted by the Regional Committee for South-East Asia at its sixty-fifth session. The Executive Board would also be considering a draft resolution on

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<sup>1</sup> Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA66.4.

autism at its 133rd session and he urged Member States to support it. He endorsed the draft resolution on disability but pointed out that his country would need technical support for gearing up activities to prevent and control disabilities.

Dr CHAND (Nepal), speaking on behalf of the Member States of the South-East Asia Region, commended the draft resolution on disability. It was estimated that 15% of the population of his Region had a disability. The plight of people living with disability had been recognized in several recent international resolutions and would be given further exposure as a result of the High-level Meeting of the United Nations General Assembly on disability and development to be held on 23 September 2013.

He proposed the following amendments to the draft resolution. The words “through universal health coverage” should be inserted at the end of the eighth preambular paragraph; the word “their” should be replaced by “both formal and informal caregivers” after “Noting that” in the tenth preambular paragraph; the phrase “as mentioned in Article 5 of the Convention” should be inserted after “to develop” in subparagraph 2(2); and the words “to gather appropriate sex and age-disaggregated data” should be replaced with “to establish and strengthen monitoring and evaluating systems” in subparagraph 2(3). Also, subparagraph 2(8) should be rephrased to read: “to consider providing health services to the disabled as an investment rather than expenditure; it will reduce discrimination and denial and increase respect for the rights of the disabled”; and the phrase “and Member States” should be inserted after “United Nations organizations” in subparagraph 3(6). He further proposed inserting an additional paragraph between the seventh and eighth preambular paragraphs of the draft resolution, which would read: “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.”

Professor PRASAD (India) drew attention to the need to recognize clearly the difference between physical disability and disability caused by mental illness, especially in terms of the stigmatization of people with mental disorders and the loss of capacity in the context of access to treatment. The rights of persons with disabilities, laid down in the United Nations Convention on the Rights of Persons with Disabilities, differed across a range of disabilities and the responses required in some cases went beyond the purview of the health sector.

Mr BEDFORD (Australia) expressed support for the draft resolution and its adoption by the Health Assembly; it would be a useful prelude to the High-level Meeting of the United Nations General Assembly on disability and development. The draft resolution highlighted the recommendations contained in the *World report on disability* and the health aspects of the United Nations Convention on the Rights of Persons with Disabilities, and its adoption would allow the Health Assembly to consider those recommendations. He congratulated WHO and the World Bank on producing the *World report on disability*, for which his country had provided financial backing. That report confirmed that persons with disabilities encountered a range of barriers in attempting to access health services, leading to unmet health needs.

Dr DATOR (Philippines) strongly recommended that the Health Assembly adopt the draft resolution. His Government recognized its responsibility for ensuring that persons with disabilities had full access to health care services, that informal caregivers received the support they needed, and that rehabilitation services were made available, so that persons with disabilities could participate fully in society, all of which depended on a multisectoral approach. He outlined the steps that had been taken in his country in that regard, including a five-year plan covering persons with disabilities. He urged the Secretariat to expedite the release of the standardized disability survey instrument so that it could be implemented in countries, thereby improving the reliability of data. The forthcoming High-level

Meeting of the United Nations General Assembly should encourage governments to give priority to the concerns of persons with disabilities.

Ms WENDLING (Germany) expressed support for the draft resolution and described the steps that had preceded the adoption in her country of an action plan to ensure the inclusion of persons with disabilities, as a prelude to implementation of the United Nations Convention on the Rights of Persons with Disabilities.

Dr KAMALIAH MOHAMAD NOH (Malaysia) commended the report on disability and the efforts being made to mainstream the subject. She described the approach being adopted in her country, some aspects of which were being implemented in order to maximize the use of scarce resources. Although the International Classification of Functioning, Disability and Health worked well at the individual level and for comparing data across countries, its use in primary care needed to be reconsidered. She therefore requested the Secretariat to prepare a generic core data set that was suitable for primary health care settings. She endorsed the draft resolution.

Dr KESKINKILIÇ (Turkey) expressed support for both the report on disability and the draft resolution. In order to improve the quality of life of persons with disabilities, measures dealing with both health and social needs, as well as support from other United Nations agencies, were needed. He looked forward to the prompt availability of the guidelines on rehabilitation being prepared by the Secretariat and emphasized the need to include disability in the post-2015 development agenda.

Dr GHEBREHIWET (Eritrea), speaking on behalf of the Member States of the African Region, stated that disability extended beyond the sphere of health and had social and environmental implications that also needed to be tackled. In Africa, people with disabilities encountered a range of barriers, including barriers to health care, education, transport, employment, physical infrastructure and communication. Only a small percentage of people with disabilities received the assistance they needed. The United Nations Convention on the Rights of Persons with Disabilities reinforced the understanding of disability as an issue relating to human rights and development, but he expressed concern about its effective implementation in Africa, because of a shortage of dedicated professionals, insufficient reliable data on disability, and weak policies and legislation. He therefore recommended that the health sector should adopt the relevant articles in the Convention, including those on health and rehabilitation.

Ms FERNÁNDEZ DE LA HOZ ZEITLER (Spain) said that WHO's work on disability should be guided by the United Nations Convention on the Rights of Persons with Disabilities, which had changed its focus from a medical and rehabilitation perspective to one centred on human rights. Her Government had already shown its commitment to improving the lives of people with disabilities, but more strenuous efforts in promoting their rights were needed. The report contained in document A66/12 provided novel approaches to supporting people with disabilities; she endorsed the draft resolution, particularly as it took account of recent developments. Her Government, with that of the Philippines, had been named co-facilitator of the final document for the High-level Meeting of the United Nations General Assembly on disability and development in September 2013, which she hoped would serve to strengthen countries' commitment to integrating the rights of persons with disabilities in overall human development actions.

Ms GREENLEE (United States of America) expressed broad support for the draft resolution and proposed amendments to subparagraph 2(7) such that it would then read: "to promote and strengthen integrated community-based supports and services as a multisectoral strategy that empowers all persons with disabilities to access, benefit from, and participate fully in inclusive education, employment, health and social services". She also proposed that the words "supports and services" be inserted before "and health" in subparagraph 3(5). She recommended using "supports and

services” where possible rather than “rehabilitation programmes”, to communicate the idea that human beings exist along a continuum of abilities. WHO should continue to exercise leadership in improving health and socioeconomic outcomes and furthering full inclusion of persons with disabilities, ensuring that the latter continued to be actively engaged in the design and implementation of such efforts. She commended WHO’s commitment to inclusiveness in its own sphere of activities. With regard to the amendments proposed by the delegate of Nepal, the idea of separating out different types of disability, such as those related to mental health or autism, gave cause for concern, as in her view such a distinction was not desirable.

Mr EMANUELE (Ecuador), speaking on behalf of the Member States of the Union of South American Nations, said that they were making significant efforts to advance in the area of disability, with a view to ensuring inclusion and access to integral health services for people with disabilities, thereby safeguarding their rights. The region had a record of successful experiences that had served as benchmarks for other States in Latin America, leading to successful cases of South–South and triangular cooperation.

Global estimates of the number of people with some form of disability – 15% of the world population – were alarming, and countries needed to provide a stronger response to the issue, which had long been considered a minor matter. He encouraged WHO Member States to approve the draft resolution, thereby committing themselves to strengthen their response. A good plan of action entailing a holistic approach was also important if the resolution was to be of practical benefit to those suffering from some form of disability. To that end, he recommended consultations with all interested parties that focused on the requisite intersectoral approach and on discussion of aspects such as operational concepts, criteria for assessing the seriousness of disabilities, types of disability, involvement of health teams and social networks, dissemination of the results, and in particular the role of international cooperation. Those discussions should be based on successful experiences in different regions and subregional initiatives such as the Andean disability policy. It was also important for the plan to be structured and coordinated with other international instruments, such as the Convention on the Rights of Persons with Disabilities and with the outcomes of the United Nations General Assembly High-level Meeting on disability and development, and that it should follow the WHO reform guidelines, thereby strengthening health governance. WHO should set aside the resources needed to prepare the plan of action, thereby ensuring its timely implementation.

Dr NDIAYE (Senegal) said that in Senegal 1.4% of a total population of 10 million lived with a disability. Specialized services were rare and mainly located in the larger towns. His Government had ratified the United Nations Convention on the Rights of Persons with Disabilities and had also introduced legislation and measures of its own to improve the lives of persons living with disabilities. As well as endorsing the draft resolution, he welcomed the recommendations contained in the report, in particular the involvement of people with disabilities in the implementation of the recommendations and strengthening the capacity of health professionals in the field of disability. A presidential council on disability was due to be organized in his country during the next three months in order to highlight the need to include the target group in policy-making. He requested financial and technical support to facilitate the achievement of the objectives.

Dr DIAZ ANAIZ (Chile) commended the report on disability. In line with its commitments under the United Nations Convention on the Rights of Persons with Disabilities, his Government had introduced legislation that focused on strengthening rehabilitation services through their integration in the national health care system. It had also prepared guidelines on treating people with disabilities; given priority to managing autism, blindness and visual impairment; provided support to caregivers; enhanced the training of health care workers, and introduced a new classification network based on the International Classification of Functioning, Disability and Health. Thus he strongly supported the draft resolution as it reflected the measures already being taken in Chile and would serve to place disability firmly on countries’ agendas.

Dr AL-TAAE (Iraq) said that the approach taken in Iraq centred on the integration of services for the prevention and early detection of disability in all levels of health care. Early detection of disability should be a component of countries' medical services, including for family medicine, reproductive health, nutritional needs, birth defects, micronutrient deficiency, and injuries and accidents, as well as being part of a disaster response system. He emphasized the role of health promotion and community-based initiatives and drew attention to the implications of disability and its prevention for social determinants of health.

Mr LAHLOU (Morocco) said that Morocco had adopted numerous legal, institutional and organizational instruments over the past 20 years that were based on and fully consistent with the recommendations referred to in the report. It had enacted laws and decrees enshrining the rights of persons with disabilities. In 1995 Morocco had established the Office of the High Commissioner for Persons with Disabilities and in 2003 the Office of the Secretary of State for the Family, Solidarity and Social Action, which had become the Ministry of Solidarity, Women, the Family and Social Development in 2007. On 8 April 2009 Morocco had ratified the Convention on the Rights of Persons with Disabilities and in 2011 it had adopted a new Constitution, Article 34 of which required the public authorities to formulate and implement policies on behalf of individuals and groups with special needs.

As prevention played a key role in impeding any increase in disability rates, the Ministry of Health made preventive services available to such groups through health care institutions. It was also developing special medical training facilities, promoting the production of artificial limbs and the correction of deformities, ensuring supplies of medical equipment, developing strategies aimed at building professional capacity and promoting partnerships with actors working on behalf of persons with disabilities. Morocco requested WHO's support for the implementation of various measures under its Action Plan for 2012–2016.

He made four proposals. First, standard tools should be used for the compilation of data concerning disabilities and Member States should adjust them in the light of the prevailing social and economic context. Secondly, in the interests of equality and non-discrimination, the term "persons with disabilities" should be replaced with "persons with limited participation in occupational, social and family life". Thirdly, given the diversity of disabilities and associated needs, an integrated strategy should be developed for each type of disability, with countries taking into account all preventive, relief and therapeutic dimensions in each case. Lastly, Member States should be encouraged to share their expertise and the results of successful experiments.

Mr JONES (Canada) said that the federal Government was committed to improving the social and economic inclusion of persons with disabilities and to respecting its obligations under the United Nations Convention on the Rights of Persons with Disabilities. He supported the draft resolution with the amendments proposed by the delegate of the United States of America and acknowledged the need to gather information on the situation of persons with disabilities, as called for in subparagraph 2(3).

Dr AL WAHAIBI (Oman) proposed that an integrated and multisectoral approach should be adopted to elimination of the barriers encountered by persons with disabilities. The incorporation of a disability perspective into development was also an appropriate and productive way of meeting the needs of persons with disabilities. He supported adoption of the draft resolution.

Dr PITAKPOL BOONYAMALIK (Thailand) welcomed the recommendations contained in the *World report on disability* as they represented strategies for implementing the United Nations Convention on the Rights of Persons with Disabilities. Thailand would be ready to participate in future work and in the drafting of a comprehensive action plan. He strongly supported the draft resolution but pointed out that people with mental disorders disproportionately encountered barriers to the full enjoyment of their rights, and that specific actions and indicators should therefore be included in any



future action plan. A strategy for mitigating the stigmatization attached to disability should also be included.

Dr SADRIZADEH (Islamic Republic of Iran) welcomed the comprehensive report on disability. He drew attention to the consequences that could arise from placing too strong a reliance on institutional solutions, as well as to problems associated with a lack of community living and with inadequate services that left people with disabilities isolated and dependent on others. Ensuring the independence of disabled persons should therefore be a pillar of national disability strategies and action plans. It was also important to reinforce the dignity of people with disabilities by preventing discrimination and stigmatization. The answer lay in appropriate national policies and strategies, as well as a comprehensive multisectoral approach that people with disabilities were involved in formulating.

Mr VIEGAS (Brazil), noting the particular vulnerability of people with disabilities to avoidable secondary health problems related to ageing, poverty, education and other social determinants of health, highlighted the need for inclusive policies, especially in developing countries. He outlined the measures and policies being adopted in Brazil to improve the lives of people living with disabilities, including strengthening their basic rights in the areas of education, transport, professional qualifications, accommodation and health.

Recognizing the importance of the support and leadership of WHO, he supported the proposal of the delegate of Ecuador calling for a plan of action to be prepared, for submission to the Sixty-seventh World Health Assembly. He supported the draft resolution.

Professor ELIRA-DOKEKIAS (Congo) pointed out that the nature of disability required a multisectoral rather than an exclusively health sector approach. The report and draft resolution focused on rehabilitation rather than on identifying and controlling risk factors or determinants, which particularly affected the African Region. The report should have included poliomyelitis and alcohol consumption by pregnant women as they represented significant risk factors; poliomyelitis eradication and raising awareness of the harmful effect of alcohol consumption on babies should be included in the draft resolution. Both aspects were preventive in nature and represented an integrated approach to managing disability.

Dr NGOC KHUE LUONG (Viet Nam) proposed the following amendments to the draft resolution: the words “and to improve their quality of life” should be inserted after “human rights” in paragraph 1; the words “social protection” should be added after the words “adequate financing” in subparagraph 2(4); and the words “technical and financial” should be inserted after “to provide” at the beginning of subparagraph 3(1).

Dr BASTAKI (Kuwait) urged WHO to include adoption of the forthcoming action plan in its future agenda. She outlined numerous ways of preventing or reducing the likelihood of disability, including improved pre- and postnatal care and premarital counselling, particularly in highly consanguineous communities, pre-conception screening for genetic disorders, and improving newborn screening programmes to include all conditions that could lead to disability.

Professor MESBAH (Algeria) endorsed both the report and draft resolution on disability, noting that they validated Algeria’s long-standing approach of including prevention and management of disabilities in all public policies.

Mr HOLM (Sweden) welcomed the increased attention being paid to disability by the United Nations, adding that it must be translated into concrete action. The United Nations Partnership on the Rights of Persons with Disabilities augured well. The High-level Meeting of the United Nations General Assembly on disability and development, to be held in September 2013, would provide an

opportunity to consider all aspects of disability in the context of the post-2015 development agenda. He expressed support for the draft resolution and especially welcomed the provisions on improved data collection contained in the draft resolution and commended the inclusion of statistics and indicators in the *World report on disability*. Standardized and internationally comparable data were essential for benchmarking and monitoring progress, as well as in following up on attainment of the Millennium Development Goals and in preparing a post-2015 development framework. He supported the drafting of a comprehensive action plan on disability for submission to a future Health Assembly.

Ms Su-Wen TENG (Chinese Taipei) endorsed the recommendations contained in the draft resolution on implementing the provisions of the United Nations Convention on the Rights of Persons with Disabilities. She outlined some measures that had been introduced in Chinese Taipei to promote the rights of people living with disabilities, including legislation and systems for identifying and assessing disability in accordance with the International Classification of Functioning, Disability and Health, as well as a model linking disability evaluation and social welfare. Chinese Taipei looked forward to sharing its experiences and contributing to the work of the international community.

Ms FENU (CBM), speaking at the invitation of the CHAIRMAN, said that the recommendations contained in the *World report on disability* provided a comprehensive framework for action and had raised awareness of disability-related issues at the national level. She urged WHO to continue its work on the topic through a participatory and multisectoral approach, taking into account the views of nongovernmental organizations, representatives of disabled persons' organizations and persons with disabilities themselves; to support a disability-inclusive post-2015 development agenda, with particular emphasis on data collection, health care and rehabilitation; to provide support to Member States for the collection of disaggregated data on disability; and to continue its internal reform to develop into an organization that was inclusive and accessible to persons with disabilities.

Dr TONNEVOLD (International Society for Prosthetics and Orthotics), speaking at the invitation of the CHAIRMAN, after describing the success of his life after being fitted with two prosthetic legs, said that there was a wide range of assistive technologies available, such as prostheses, orthoses and wheelchairs, which could enable persons with physical disabilities to become healthy, independent and productive members of society. It was estimated that 354 million persons worldwide would benefit from such devices, but only 5% to 15% of current needs were being met. The need for those devices would only continue to rise as a result of the growing prevalence of noncommunicable diseases and the increase in ageing populations. He encouraged WHO to prioritize access to assistive technologies and promote a global initiative to increase access to such devices.

Ms SYKES (World Confederation for Physical Therapy), speaking at the invitation of the CHAIRMAN, said that steps needed to be taken to redress the imbalance in access to health services experienced by person with disabilities. Consultation with physical therapists and other rehabilitation specialists, and investment in education, were essential in the development of national disability strategies, programmes and services. Moreover, collection of reliable and accurate data was needed in order to inform policies and programmes, and she encouraged Member States to use the International Classification of Functioning, Disability and Health to that end.

Ms KOCA (World Blind Union), speaking at the invitation of the CHAIRMAN, said that the social model of disability reflected in Article 1 of the United Nations Convention on the Rights of Persons with Disabilities should form the basis of all efforts to protect the rights of such persons. Owing to exclusion and discrimination, persons with disabilities often had unmet health care needs and disproportionately poorer levels of health than the general population. The draft resolution should take into account the need for consultation with persons with disabilities and their representative organizations; should ensure that WHO took account of the rights of persons with disabilities when

fulfilling its mandate; should recommend that international cooperation activities be funded only if they included attention to the rights of persons with disabilities; and should ensure that persons with disabilities and their representative organizations be consulted during elaboration of the comprehensive action plan.

Professor GUTENBRUNNER (International Society of Physical and Rehabilitation Medicine), speaking at the invitation of the CHAIRMAN, said that rehabilitation was a core health strategy and that equity of access to rehabilitation programmes and health services was a basic human right. The *World report on disability* had stated that a lack of reliable research hindered the development and implementation of effective rehabilitation policies and programmes; consequently, he urged Member States to undertake and promote scientific research on functioning and disability, to strengthen international cooperation on research in that area, and to facilitate access to scientific and technical knowledge relevant to the lives and living conditions of persons with disabilities. The importance of research should be explicitly reflected in the action plan that would be developed.

Mr MONSBAKKEN (Rehabilitation International), speaking at the invitation of the CHAIRMAN, said that both the draft resolution and the *World report on disability* provided a clear picture of the barriers faced by persons with disabilities that needed to be addressed. He urged WHO to ensure the implementation of the recommendations from the report and to use the United Nations General Assembly High-level Meeting on disability and development as an opportunity to raise awareness of the need to address the problems faced by persons with disabilities.

Miss DHATT (International Federation of Medical Students' Associations), speaking at the invitation of the CHAIRMAN, said that of the 1000 million people worldwide living with disabilities, 180 million were young people. Young people faced unique issues, including access to education, employment, health care and social services, as well as experiencing increased prevalence of mental health issues and sexual and reproductive health needs; those challenges were further compounded for young persons living with disabilities. Their views and needs should therefore be taken into account in discussions about disability. Moreover, it was crucial that persons with disabilities were included in policy-making processes, and that steps were taken to ensure that they had equal access to all public activities and services. Health care workers should also be educated to increase their awareness of the health needs of persons with disabilities and the need for respectful and professional treatment, and to further understanding of the causes, consequences and treatment of disabling conditions.

Dr KRUG (Injuries and Violence, Prevention of Disability), acknowledging the comments made, agreed that it was important to look at the issue from a human rights perspective as well as from a health perspective. He welcomed the comments on the *World report on disability* and stressed that WHO would continue to provide support for data collection. Many delegates had highlighted the importance of the comprehensive action plan referred to in the draft resolution and he looked forward to working with governments, civil society and persons with disabilities on the development of that plan. Responding to the comment by the delegate of Sweden, he explained that if Member States wanted to have the draft action plan ready by the Sixty-seventh World Health Assembly, that would entail preparing it in time for the 134th session of the Executive Board in January 2014. Given that the action plan was expected also to take into account the outcomes of both the High-level Meeting, in September, and consultations with relevant stakeholders, the time frame would be very tight. He asked for guidance from Member States on whether they wanted the plan drafted quickly, with limited consultations, or over a longer period of time with more extensive consultations.

The CHAIRMAN said that, owing to the large number of proposed amendments, the Secretariat would prepare a revised version of the draft resolution for discussion at a later meeting.

(For continuation of the discussion and approval of the draft resolution, see the summary record of the eighth meeting, section 3.)

## **2. PROMOTING HEALTH THROUGH THE LIFE COURSE: Item 14 of the Agenda**

### **Monitoring the achievement of the health-related Millennium Development Goals and Health in the post-2015 development agenda: Item 14.1 of the Agenda (Documents A66/13 and A66/47)**

The CHAIRMAN drew attention to the reports by the Secretariat contained in documents A66/13 and A66/47 and explained that a draft resolution submitted by the Member States of the African Region would be available the following day.

Dr SADRIZADEH (Islamic Republic of Iran) said that the Millennium Development Goals had been highly effective in focusing global attention on development issues and galvanizing support. However, inherent weaknesses had been noted in the health-related goals. It was important to build on the momentum created by the Millennium Development Goals while looking at development issues from a wider perspective in order to produce an updated development agenda that encouraged the fulfilment of global commitments at all levels. Effective international cooperation and adequate support mechanisms would be vital if future development goals were to be achieved. Despite problems related to economic sanctions, his country had made progress towards most of the Millennium Development Goals; however, health inequalities in remote areas and for deprived population groups continued to present a challenge. It had been recognized that the root causes of such inequities needed to be addressed; to that end, community-based interventions had been developed and a holistic approach, including intersectoral collaboration, had been advocated.

Ms BOTERO HERNANDEZ (Colombia) said that any Millennium Development Goals that had not been met by even a small number of countries would obviously continue to resonate on the global development agenda, and efforts and resources should continue to be allocated to monitor and fulfil them. Colombia, generally speaking, had made significant progress on all indicators, although some serious challenges remained in the run-up to 2015, owing in large part to regional divides.

The current situation provided a unique opportunity to draw up a broader, more strategic and more inclusive global development agenda, in which the concept of sustainable development would be a mainstream theme. As health was a right on which enjoyment of all other rights depended, the global development agenda required strategic health objectives that, if fulfilled, would facilitate its implementation. By the same token, multisectoral work would be needed to attain those health objectives, which should also encompass a holistic understanding of health matters. The post-2015 development agenda should include at least two groups of health indicators, one relating to the population's health, the other to national health system reinforcement. The latter should measure health system performance in terms of universality, equity and quality. Formulating indicators to measure and monitor those variables worldwide was no easy task, but was not impossible if all stakeholders contributed and WHO and the other players involved provided technical support.

Mr SMIDT (Denmark), also speaking on behalf of Australia, Belgium, Botswana, Czech Republic, Estonia, Ethiopia, Finland, Germany, Ghana, Iceland, Latvia, Lithuania, Luxembourg, Mexico, Monaco, Mozambique, the Netherlands, Norway, Portugal, Slovenia, Somalia, Spain, Sweden, Switzerland, the United Kingdom of Great Britain and Northern Ireland and Uruguay, said that an essential part of Millennium Development Goal 5 (Improve maternal health) comprised sexual and reproductive health and rights, which should be a key element in the health-related aspects of the post-2015 development agenda. In order to reduce the risks to women and adolescent girls' health resulting from pregnancy complications and forced early marriage and early pregnancy, it was important to focus on the empowerment of women and gender equality. In order to meet health-related challenges after 2015, legal systems should support the human rights of all persons, and health care systems should ensure the right to make informed choices about all aspects of health and well-being, providing access to health services and essential medicines for all, including marginalized groups. Improvements in sexual and reproductive health would have a positive impact on women, men and

families and would contribute to poverty eradication, a reduction in maternal and child mortality and the achievement of sustainable development.

Dr FREDERICKS-JAMES (Saint Lucia) underlined the need to ensure that the gains made with regard to the health-related Millennium Development Goals were not lost and that health continued to be a prominent part of the post-2015 development agenda. However, the health of a population could not be assured solely by the health sector, a concept that was reflected in the Declaration of Port-of-Spain, which recognized the importance of a multisectoral, multidisciplinary, whole-of-government and whole-of-society approach. Saint Lucia was working towards universal health coverage, health being a human right, and believed in the value of primary and preventive health care, health education and the promotion of healthy lifestyles; those fundamental, low-cost, high-impact measures should not be sidelined in the future.

**Dr Ross took the Chair.**

Mr SHI Guang (China) said that Member States should focus on identifying major outstanding challenges in order to achieve the Millennium Development Goals by 2015; WHO and the international community should concentrate on regions that were lagging behind in the achievement of those Goals and make use of cost-effective interventions in order to reduce inequalities. In addition, developed countries and international organizations should continue to make realization of the Millennium Development Goals an important area for official development assistance. On the post-2015 development agenda, the Secretariat should pursue its consultations with Member States and relevant stakeholders in order to guarantee the core position of health in that agenda. Moreover, any health-related goals that formed part of the post-2015 agenda should be linked to the Millennium Development Goals. With regard to the inclusion of universal health coverage as a goal, he suggested that the concept required further definition and that it would be important to have indicators that were measurable and comparable.

Mr SKERRITT (Saint Kitts and Nevis) said that extreme poverty had fallen significantly in his country and that participation of women in all levels of governance had become commonplace. Rates of infant and maternal mortality had also fallen considerably as a result of investment in health by the Government. Likewise, programmes on and investment in the prevention and treatment of HIV/AIDS had helped to reduce the number of new infections and tackled discrimination against persons living with HIV disease. Although Saint Kitts and Nevis had had to fund and sustain programmes for the Millennium Development Goals out of its own scarce national budget as a result of decreasing amounts of official development assistance, he expressed appreciation to Chinese Taipei for its technical and other support. Although concerned that the global economic downturn might undermine the progress made so far, he expressed his country's commitment to achieving the Millennium Development Goals.

Dr ESIN (Russian Federation) welcomed the progress made towards the Millennium Development Goals, especially in the fight against HIV/AIDS, tuberculosis and malaria, and in reducing infant mortality by increasing immunization coverage. Speeding up progress towards achievement of the Goals would require continued work to strengthen health systems and ensure their proper funding, as well as establishment of a reliable drug supply mechanism. In that context, it was important to support international initiatives aimed at strengthening surveillance and monitoring of communicable diseases, intensifying scientific research, strengthening control measures and improving access to prevention and treatment of communicable diseases.

The fight against malaria remained a global problem given its huge damage to human health and the economy of various countries. The incidence of malaria and tuberculosis or HIV co-infection was a heavy burden for health systems to bear. However, in recent years the international community's efforts to prevent and combat malaria had increased significantly, with new strategies for increased

funding. The Russian Federation had joined the campaign to eliminate malaria from the countries endemic for the disease in the European Region by 2015, and was successfully fulfilling its obligations.

**Dr Gwenigale resumed the Chair.**

Dr YANG Byung-guk (Republic of Korea) said that, although not all of the targets would be met by 2015, the efforts towards the Millennium Development Goals had been a success. In establishing the post-2015 development agenda, WHO should set more ambitious targets than those of the Millennium Development Goals, and the agenda should be developed using a systemic or schematic approach rather than a symptom-based one. In that regard, the importance of universal health coverage could not be overemphasized; it was both a means to achieve better health outcomes and a goal in itself, and it should therefore be included in the post-2015 agenda. Noncommunicable diseases were also a crucial topic that should be included.

Mr TAAPE (Tuvalu), acknowledging the support from Chinese Taipei towards achieving the Millennium Development Goals, said that Chinese Taipei had the expertise, dedication and resources to play a positive role in WHO. He therefore urged WHO to facilitate its broader participation in other WHO meetings, mechanisms and activities, on the model of its participation in the Health Assembly. It was important that all partners work together to improve health, putting aside political differences and using available resources and technologies to help those around the world that were faced with poor health conditions.

Dr USHIO (Japan) expressed appreciation for the progress made towards the Millennium Development Goals and for the work of all of those who had contributed to that progress. He strongly supported the efforts of WHO to place health on the post-2015 development agenda; the promotion and protection of health should be integral parts of development plans. Member States, the Secretariat and other partners had a fundamental role to play in advocating the importance of health for sustainable development. Japan also supported the idea of placing universal health coverage on the post-2015 development agenda.

Dr PABLOS-MENDEZ (United States of America) said that the Millennium Development Goals had become a symbol of global commitment to promoting development, eradicating poverty and extending opportunities to all. His country was interested in exploring the possibility of having universal health coverage as an umbrella goal in the post-2015 agenda, as there was growing momentum around the world towards that objective. The expansion of health coverage was both a means to achieve improved health outcomes and a goal that would provide people with financial protection and peace of mind. The post-2015 goals should build upon the work done in the framework of the Millennium Development Goals, particularly the progress made on reducing maternal, newborn and child mortality and deaths from HIV/AIDS, malaria, tuberculosis and other major infectious diseases. Ambitious goals should be set, such as ending preventable maternal and child deaths and creating an AIDS-free generation. Those objectives could be stand-alone goals or could fit within a broader goal such as universal health coverage. In addition, the post-2015 goals should include indicators on noncommunicable diseases, the fastest growing burden of disease around the world.

Dr MADZORERA (Zimbabwe), speaking on behalf of the Member States of the African Region, said that, despite the progress reported in document A66/13, many countries, particularly some in Africa, would not be able to achieve the Millennium Development Goals by 2015. Consequently, health-related Millennium Development Goals 4, 5 and 6 would be unfinished and should be included on the post-2015 development agenda; Targets 1.C, 7.C and 8.E were also relevant and should likewise be included. There was a need for increased investments in order to accelerate progress towards achieving the Millennium Development Goals by 2015.

Experience had shown that it was important to look holistically at health-related efforts; the underlying social determinants of health fell outside the scope of health ministries and lack of attention to those determinants hindered progress towards universal health coverage. In order to place health issues on the post-2015 development agenda, a framework to address the social determinants of health was needed; WHO had an important role to play in that regard, and its role as the leading United Nations agency on health should not be diluted. The Millennium Development Goals had mainly focused on the goal rather than the means to achieve that goal; an appropriate and cohesive supporting mechanism had not been adequately constructed or monitored. Thus, the post-2015 development agenda should also include mechanisms for monitoring the means used to achieve the goals as well as the goals themselves. Future monitoring mechanisms should also consider horizontal linkages across sectors, such as the social determinants of health.

Dr SAENGNAPHA UTHAISAENGPHAISAN (Thailand) said that her country supported health system strengthening and advocated having universal health coverage as an overarching development goal within the post-2015 development agenda, as such coverage minimized health-related spending by households, enabled access to health care for all and held governments accountable for investing more in the health of the population. Moreover, universality was an important instrument to help ensure the right to health for all. Increasing numbers of countries were moving closer to universal coverage, meaning that such a goal would be realistic and feasible.

Professor ARSLAN (Bangladesh) said that his country had made significant progress towards achieving Millennium Development Goals 4, 5 and 6; the mortality rate among children under five years of age had been reduced to below the target figure for 2015, and maternal health coverage indicators were improving. Those successes were the result of multiple interventions, including roll-out of the Integrated Management of Childhood Illness approach and measures related to education for women and poverty reduction. However, challenges remained: neonatal deaths accounted for 60% of all deaths in children under five years of age and there were critical shortages of medical personnel, particularly midwives and nurses. Retention of human resources in remote areas was also a problem. To overcome those challenges, Bangladesh was focusing on preventing deaths among neonates from illnesses such as pneumonia and diarrhoea and from problems such as premature birth and low birth weight. Pregnancy-related services were also being scaled up. He urged the Secretariat to provide technical support to help Bangladesh achieve the Millennium Development Goals and fulfil its dreams after 2015.

Mr LOEBELL (Switzerland) said that the Millennium Development Goals had resulted in unprecedented levels of progress in the health sector, although such gains remained fragile. It was important to move away from a fragmented approach focusing on diseases and health services and develop objectives that, while universal, enabled different approaches based on individual country situations. It was promising that the consultations currently being held seemed to be producing similar opinions. The post-2015 development agenda should contain a specific health objective related to maximizing health at all stages of life. In order to achieve such a goal, the health sector should work more actively and closely with other sectors on social, economic and environmental determinants of health; at the same time, it must also work to ensure the full continuum of health services. Universal health coverage would ensure that the whole population had access to services without any form of discrimination or inequity and without incurring catastrophic expenses. WHO should ensure that the right to health care was consolidated in the post-2015 development agenda, and indicators to monitor progress should also be defined.

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, the Republic of Moldova, Armenia, Georgia and Ukraine aligned themselves with her statement. The Millennium Development Goals had made the world a better place, but inequities still existed;

although progress had been made on Goals 4 (Reduce child mortality) and 6 (Combat HIV/AIDS, malaria and other diseases), more needed to be done, especially as mortality from infectious diseases could rebound quickly if the focus was shifted away from them. She fully supported the principles of country ownership and health system strengthening. In order to accelerate progress towards achieving Millennium Development Goal 5 (Improve maternal health) and Target 5B (Achieve universal access to reproductive health), a special focus was needed on sexual and reproductive health programmes that provided gender-specific information, particularly for young people.

More effort was also needed with regard to health systems strengthening and addressing cross-cutting challenges, such as human rights, equity, gender equality, democracy and good governance. The Secretariat should provide information to Member States on the most effective ways to achieve the best outcomes in that regard; WHO country offices should provide increased support to Member States for the realization of their national plans. In addition, the International Health Partnership should be the preferred framework for applying the principles of aid effectiveness to health matters. Investing in health helped to tackle the root causes of underdevelopment, namely poverty and instability and, as such, health should be a cornerstone of the post-2015 development agenda. The Secretariat and Member States had a crucial role to play in ensuring that health achieved its rightful place on that agenda.

Mr ÁLVAREZ LUCAS (Mexico) said that his country was ready to contribute to the development of the post-2015 development agenda and was willing to share its experiences with other countries in areas such as systems for the protection and promotion of health.

(For continuation of the discussion, see the summary record of the sixth meeting, section 2.)

**The meeting rose at 17:25.**



## **SIXTH MEETING**

**Thursday, 23 May 2013, at 09:10**

**Chairman:** Dr W.T. GWENIGALE (Liberia)

**later:** Dr L.G. ROSS (Solomon Islands)

**later:** Dr W.T. GWENIGALE (Liberia)

### **1. SECOND REPORT OF COMMITTEE A (Document A66/65)**

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

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

### **2. PROMOTING HEALTH THROUGH THE LIFE COURSE: Item 14 of the Agenda (continued)**

**Monitoring the achievement of the health-related Millennium Development Goals and Health in the post-2015 development agenda:** Item 14.1 of the Agenda (Documents A66/13 and A66/47) (continued from the fifth meeting, section 2)

Dr AL-TAAE (Iraq) said that, in order to maintain the progress achieved thus far, it would be necessary to refine the indicators and targets of the Millennium Development Goals in the post-2015 development agenda, taking into account the need for sustainability. He further suggested the establishment of a “maintenance workplan” to ensure that those indicators and targets were regularly updated in line with current epidemiological, demographic and other trends. The indicators should be incorporated into national strategies and plans, not only at the level of health ministries but also within strategic development workplans. Multisectoral collaboration and community participation were also vital to ensure sustainable development in the post-2015 environment. Health development should form part of development actions and policies across a wide range of sectors, contributing to the promotion of health through healthy life skills and lifestyles.

Ms BRANCHI (France) said that health should continue to be a crucial element in the post-2015 development agenda so as to build on the results achieved in relation to the Millennium Development Goals and because health was an indicator of sustainable development. Highlighting the need for innovative financing and the mobilization of national and international resources for health development in the post-2015 agenda, she noted that effective low-cost interventions existed and should be enhanced, such as prevention, action on social and economic determinants of health, gender equity, and access to sexual and reproductive health services. Universal health coverage was both a political aspiration and a specific objective that had a direct impact on the health of all peoples. Strengthened health systems were needed in order to reach the targets of the health-related Millennium Development Goals and combat noncommunicable diseases. Increasingly, universal health coverage was being used as a tool to reduce poverty and promote equity and sustainable development, the

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

concept being to enable the most vulnerable people to access basic health services without incurring financial difficulties. The United Nations General Assembly, in its resolution 67/81 on global health and foreign policy, had recommended the inclusion of universal health coverage in the post-2015 development agenda, highlighting the need for a multisectoral approach and political commitment going beyond the health sector.

Ms REITENBACH (Germany), referring to the need to ensure that health was an integral part of the post-2015 development agenda, said that she shared the views expressed by the Director-General in her address, namely that “[h]ealth contributes to and benefits from sustainable development and is a measurable indicator of the success of all other development policies”. Comprehensive, effective, affordable, well-managed and high-quality health services could be achieved through universal health coverage and the implementation of health-related policies across a broad range of sectors, and should be driven by an equity- and rights-based approach.

Dr ESCARTIN (Philippines) said that one of the three strategic components of his country’s universal health care agenda was the achievement of the Millennium Development Goals. Progress towards them was tracked, particularly in relation to maternal health care and maternal mortality, the high rate of which was being addressed through multisectoral actions and policies. With the support of WHO, his country was developing an instrument to monitor the intermediate outcomes of the implementation of universal health coverage. The results would be used to guide future decisions and actions. His Government would continue to support global initiatives to assess the progress made towards the Millennium Development Goals.

Dr AL LAMKI (Oman) endorsed the Director-General’s view that health contributed to and benefited from sustainable development. Work on achieving the health-related Millennium Development Goals would guide future actions and must continue. In view of the risk of noncommunicable diseases at the global level, he highlighted the need to include actions to reduce related morbidity in the post-2015 development agenda.

Ms ALI (Maldives) commended the leadership of WHO and the commitment of Member States to achieving the Millennium Development Goals. She expressed strong support for the overarching goal of “well-being and happiness” proposed during the South-East Asia Regional Consultation on the Post-2015 Development Agenda held in Bangkok, Thailand from 19 to 21 March 2013. Universal health coverage was a significant element of efforts to achieve the Millennium Development Goals. Although the Goals had led to significant improvements in health, progress towards all of them had not been consistent, underscoring the need to continue global efforts. Her country had achieved five of the eight Millennium Development Goals, including Goals 4 and 5. However, like other developing countries, Maldives faced numerous challenges in sustaining its achievements, such as limited human resources and the high cost of health care. Reducing the burden of noncommunicable diseases should be given high priority in the post-2015 development agenda, and emphasis should be placed on the importance of universal health coverage. The Secretariat should continue to provide support to Member States in terms of capacity-building, especially in relation to human resources, and should encourage collaboration between Member States in their efforts to achieve the health goals.

Dr ROZITA HALINA TUN HUSSEIN (Malaysia) said that, in order to accelerate progress towards attaining the Goals, interventions must be country-specific, as countries were at different levels of achievement. WHO should use its role as the leading global health agency to guide the coordination of global efforts, in order to identify cross-cutting issues that were applicable to the achievement of universal health coverage. National surveillance capacities must be strengthened so as to capture essential disaggregated data, and to that end the Secretariat should provide support to countries with minimal resources and limited data availability, thereby allowing them to measure progress in universal health coverage and equity through the development of a set of indicators.

Ms HARB (Lebanon), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that, although commendable achievements had been made in some countries in the Region, not all Member States had made the same level of progress, owing to the diversity of the Region and the variety of its challenges, including political unrest, poverty, a low literacy rate and insufficient resources. One challenge faced by many Member States was achieving universal health coverage while optimizing investment and enhancing accountability. Further progress towards the health-related Millennium Development Goals could be made by taking action on cross-cutting problems, such as strengthening health systems, ensuring access to high-quality health care, and tackling the social determinants of health. She called on WHO, in coordination with other organizations of the United Nations system, to provide the resources needed to respond to the Dubai Declaration of 30 January 2013 on Saving the Lives of Mothers and Children: Rising to the Challenge, adopted by ministers of health and delegates of countries of the Eastern Mediterranean Region, and to provide the necessary support to Member States, particularly those experiencing political instability and civil wars.

All Millennium Development Goals were related to health. Poverty reduction and sustainable development were intrinsically linked to health; reducing poverty was therefore a key element of universal health coverage. She requested the Secretariat to provide support to Member States in the Region in their efforts to ensure fair access to quality, equitable and affordable health care services and promote healthy lifestyles, while maintaining the results already achieved in relation to the Millennium Development Goals.

Professor BAGGOLEY (Australia) said that the outcomes of the High-Level Dialogue on Health in the Post-2015 Development Agenda (Gaborone, Botswana, 4–6 March 2013) provided a good basis for further discussions on health in the post-2015 environment. Those discussions should be consultative and include broad country- and regional-level inputs. Significant progress had been made towards the health-related Millennium Development Goals, but large disparities existed between and within countries and not all targets would be met by 2015. Noting that the improvement of access to quality maternal and child health services was a key development objective of Australia's aid programme, he expressed particular concern at the lack of progress made in relation to Goal 5 and called for additional efforts to address maternal mortality. He supported WHO's work to ensure that health was an integral part of the post-2015 agenda, noting that the links between health and sustainable development must be clearly articulated and that reducing the burden of noncommunicable diseases was a crucial aspect of sustainable development. The United Nations Millennium Declaration (United Nations General Assembly resolution 55/2), with its focus on poverty reduction, should remain a key reference in the post-2015 agenda. Future goals must be clear, measurable and able to generate political commitment for health outcomes.

Dr ALHAJERI (Bahrain) thanked the Secretariat for its efforts to meet existing challenges in the Eastern Mediterranean Region, especially with respect to the post-2015 development agenda. It was essential to harmonize the action taken by United Nations agencies and their partners to achieve the Millennium Development Goals. Vigorous action was required to remove impediments to progress in some countries. It was also important to focus on areas in which delays in achieving the goals had been recorded. The fair distribution of appropriations was essential. Greater financial support and technical expertise must be made available to accelerate progress during the period prior to 2015, especially in countries that were carrying the greatest burdens in health. He supported the references in the documents under discussion to the need for speedier progress towards the achievement of the Millennium Development Goals, especially Goals 4 and 5, in the Eastern Mediterranean Region, as well as plans to achieve sustainable health for all.

Dr SEAKGOSING (Botswana) said that it was an opportune time to build on the successes achieved in relation to the health-related Millennium Development Goals, while also ensuring that their shortcomings, such as a lack of focus on equity and human rights and the absence of a multi-level consultative process, were better addressed in the post-2015 environment. Botswana had co-hosted the High-Level Dialogue on Health in the Post-2015 Development Agenda, at which participants had acknowledged the need for an overarching development goal that positioned health as a crucial contributor to, as well as an outcome of, sustainable development and human well-being. Issues related to equity, health system strengthening, accountability, partnerships and national ownership had also been highlighted as essential to the achievement of the post-2015 goals. He looked forward to the outcomes of the discussions of the Secretary-General's High-Level Panel of Eminent Persons on the Post-2015 Development Agenda. Health must retain a prominent position both in the sustainable development agenda and in the post-2015 development agenda. Furthermore, while it was important to determine the post-2015 agenda, work on achieving the current health-related Millennium Development Goals must not be sidelined.

Ms TRAVERSO ZEGARRA (Peru), speaking on behalf of the Member States of the Union of South American Nations, said that health should be viewed as a fundamental right; incorporating equity, universality and quality into health goals would allow the social, economic and environmental determinants of health to be addressed, thereby enabling multisectoral action and the inclusion of health in policies across all sectors. The Member States of the Union of South American Nations were fully committed to the discussion on health in the post-2015 environment. Referring to the impact of economic factors and the environment on health and the intrinsic link between development and health, she underlined the need to take development and sustainability into consideration when determining the post-2015 health agenda. Universal health coverage must be ensured and should include elements such as prevention, health promotion, rehabilitation, access to medicines, palliative care and work on the determinants of health; current health targets and actions, such as those related to maternal and infant mortality, must be incorporated into the post-2015 agenda.

Mr OVIEDO (Costa Rica), noting that global health inequities remained in spite of the progress made, said that work on the Millennium Development Goals must continue in the case of upper-middle-income countries such as Costa Rica, not only to achieve the agreed targets but also to maintain the progress already achieved. He expressed support for the approach of giving health a prominent position in the post-2015 development agenda. The objectives of the post-2015 agenda should be based on a clear and integral concept of health and should include targets to measure the quality and performance of health services and systems, actions related to the determinants of health, and a variety of goals to ensure access to basic services, such as sanitation and nutrition. Referring to the need to look beyond strategies targeting the provision of health services only, he asserted that additional key elements of the post-2015 agenda should include the extension of health coverage and the strengthening of primary health care, through which the determinants of health could be comprehensively addressed.

Dr BARBOSA (Brazil) said that health was the link between poverty reduction, well-being and sustainable development and, as such, together with its related elements of universality and equity, should maintain a primary role in the post-2015 agenda, thereby addressing the political, social and economic determinants of health. In particular, his country supported universal health coverage, including the promotion of effective access to health services, efforts to increase life expectancy, and work to conclude the unfinished agenda on reducing the burden of maternal and child mortality. Endorsing the emphasis in document A66/47 on a comprehensive, inclusive health objective that clearly articulated the relationship between health and poverty reduction, he stated that his country was committed to building an improved health environment for the future.

Dr DIAZ ANAÍZ (Chile) endorsed the view expressed in a WHO discussion paper in October 2012 that the Millennium Development Goals were “a powerful force in maintaining political support for development” and should be considered in the process of defining the post-2015 agenda, in order to shape future global health efforts and ensure that existing high-priority goals were completed and emerging global health issues addressed. While further efforts were needed to achieve the Millennium Development Goals, it was important to recognize the multitude of challenges faced by individual countries in achieving them. His country had made significant progress in reducing maternal and child mortality and in providing treatment for people with HIV/AIDS and tuberculosis. Given that, in many countries progress in the treatment of HIV infection had been possible as a result of more equitable access to antiretroviral therapy and prompt diagnosis, there was a need to remove all barriers to universal access to medicines.

Although the maternal mortality ratio had considerably decreased at the global level, further multisectoral, political and social efforts were needed to lower the rate in countries that still had a ratio above 100 deaths per 100 000 live births. In line with WHO’s aim of reducing early pregnancy, his country had established a range of services for adolescents, including counselling and contraceptive services, leading to a significant reduction in early pregnancy. Those policies could be replicated at the intraregional and interregional levels.

Ms CHUNG (Canada) said that the current health-related Millennium Development Goals remained highly relevant, and work on them should continue as part of the post-2015 framework. In view of the changing global health landscape, it was important to strengthen linkages with the sustainable development agenda, tackle emerging health problems such as noncommunicable diseases and the social determinants of health, ensure that due attention was paid to gender equality and equity issues, recommit to strengthening health systems, and ensure that children and youth remained at the centre of global health efforts.

Dr WOLDEMARIAM (Ethiopia) said that the Millennium Development Goals had proved to be successful in constituting a common development platform and had mobilized action to improve the lives of many people. He underlined the need to ensure the relevance of health system strengthening by maintaining country ownership and increased financing. Noting the importance of harmonizing and aligning global action to achieve health results, he emphasized that health should be an integral component of the post-2015 development agenda, which should incorporate valuable inputs from the successes and setbacks experienced in achieving the Millennium Development Goals.

Mr PIPPO (Argentina) said that construction of the post-2015 development agenda must be based on an integrated vision, with a focus on people and their communities. The post-2015 agenda must also be capable of responding to emerging challenges and place health at the forefront of global actions, in part because health provided a yardstick against which the success of multisectoral socioeconomic policies could be measured. The links between health and development should be clearly defined in the post-2015 agenda, providing impetus to policies that viewed health as a pivotal determinant in terms of its effect on socioeconomic, political and cultural development. In that connection, he noted the adverse health impacts of the recent global economic crisis.

Life expectancy could be increased by ensuring universal access to services such as safe drinking-water and sanitation, education and coverage of health services. Current and future discussions on the post-2015 agenda must adopt an integrated approach to health and consider a wide range of objectives in view of the changing global health landscape. Noting that universal health coverage and access were fundamental components of efforts to achieve the highest possible level of health for all, he highlighted the need for further work on them, including the establishment of related objectives.

Dr WAPADA (Nigeria) said that his country had made significant progress and was on track to achieve the Millennium Development Goals, especially Goals 4 and 5, as a result of national health strategies and activities to target maternal and child health. His Government was committed to ensuring universal health coverage and was in the process of enacting legislation that would improve funding for the health sector; most states in Nigeria were providing free maternal and child health services. He endorsed the post-2015 development agenda.

Mr FERDINAN TARIGAN (Indonesia) said that the Secretariat's focus on achieving the Millennium Development Goals was welcome, although further efforts were needed, particularly in relation to reducing infant and maternal mortality and HIV prevalence. Geographical and socioeconomic disparities, the lack of an adequate health workforce and low government awareness were contributory factors to the slower progress made in some countries. His Government had implemented a number of actions to achieve the Millennium Development Goals, including legislation to promote breastfeeding. The new set of objectives in the post-2015 development agenda should also cover indicators relating to well-being and happiness, and should include not only well-managed, effective public health initiatives to promote healthy behaviour but also partnerships to promote universal access to health care. His country had set aside a significant budget to ensure universal access to health care for all its citizens.

Dr VALLEJO (Ecuador) said that, in order to have a genuine impact on future development, a holistic and integrated approach to health was required. In his country, health was regarded as a component of overall well-being. His Government was working to ensure that health was integrated into all policies, and its multisectoral action, together with political commitment, had led to substantial progress in reducing poverty and inequity.

The post-2015 development objectives should focus on the principle of equity and on the social determinants of health, thereby helping to reduce health disparities among countries. The process to develop the post-2015 objectives, which would not be easy, should be inclusive and open to all Member States and must be shaped by feedback at the global, regional, subregional and national levels. It was important to continue efforts to achieve the current Millennium Development Goals, especially those related to maternal and child mortality, while maintaining and building on the results achieved. A variety of strategies should be implemented, including a monitoring and evaluation framework to measure progress in achieving the post-2015 objectives and a clear set of indicators would therefore need to be established. In that context, the Secretariat at headquarters and in regional offices must provide technical support to Member States.

Dr ST. JOHN (Barbados) said that the Millennium Development Goals had focused global efforts to redress inequities and had resulted in significant progress even in a time of global unrest, socioeconomic upheaval and economic instability. She supported the aim of completing the Millennium Development Goal agenda in the post-2015 environment, but emphasized that the post-2015 objectives must focus more sharply on human rights and gender-based approaches, among other principles enshrined in the United Nations Millennium Declaration (United Nations General Assembly resolution 55/2). Noting that a global, multisectoral approach with an emphasis on prevention would be essential to tackle noncommunicable diseases, she urged Member States to promote efforts in that regard. She endorsed the life course approach to addressing health needs in the post-2015 agenda and the proposed focus on wellness rather than illness. Efforts to ensure universal health coverage were essential and would not only lead to strengthened health systems and better quality health care delivery but would also give countries the flexibility to determine their package of health services and the method of providing sustainable financing for those services.

Dr MARTÍNEZ DE CUELLAR (Paraguay) said that, although many of the Millennium Development Goals would not be achieved in her country despite considerable efforts to do so, Paraguay had made progress towards some, including a reduction in maternal and child mortality and in mortality and morbidity due to HIV infection and tuberculosis, as well as the eradication of malaria. Global strategies must be identified to accelerate progress towards those Goals that could be achieved by 2015. She also highlighted the need to mobilize efforts, strengthen the network of health services and secure sufficient resources in order to achieve the forthcoming objectives of the post-2015 agenda, which should contain not only clear actions to maintain the success achieved to date but also actions that would contribute to achieving the Millennium Development Goals that had not yet been attained. The post-2015 agenda should further include objectives to tackle the social determinants of health, such as universal access to health, safe drinking-water and education.

Dr AFZAL (Pakistan) noted that the Millennium Development Goals had helped to shape political agendas, had served as fiscal instruments and had helped to institutionalize policies, but, despite the gains made, the Goals must be regarded as unfinished business. At the same time, it was important to build further on the aspirations underlying them. The post-2015 framework should include: mainstreaming the Millennium Development Goals in public health planning; embracing universal health coverage and access as a policy goal; putting in place structures to compel accountability; and paying attention to factors outside the health sector that shaped human well-being. Putting health at the heart of the post-2015 development agenda would not only save lives and enhance economic development, but would also contribute to environmental sustainability and the advancement of well-being and social justice.

The CHAIRMAN drew the Committee's attention to the draft resolution proposed by the Member States of the African Region.

Dr GWINJI (Zimbabwe) said that the Health Assembly needed to make a clear statement to the international community as to the importance of placing health at the centre of the post-2015 development agenda. To that end, he presented the following draft resolution on health in the post-2015 agenda, and proposed that an informal working group of interested Member States be convened to further strengthen the drafting of that resolution.

The Sixty-sixth World Health Assembly,

PP1 Recalling global, regional and national health consultations on the post-2015 development agenda which are still underway;

PP2 Reaffirming the WHO Constitution which states that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition;

PP3 Appreciating the need to sustain current commitments and interventions on the health related MDGs;

PP4 Ensuring that the process of defining the post-2015 agenda does not detract ongoing efforts to achieve MDG targets by 2015 and builds on the strong foundation established towards the attainment of these goals;

PP5 Recognising that health is central to human development as both a contributor and outcome and that Universal Health Coverage is an important measure of development;

PP6 Cognisant of the importance of a whole of Government, whole of society and health in all policies approach towards a common post-2015 agenda;

PP7 Cognizant of the need for a holistic approach by addressing the determinants of health;

PP8 Underlining the importance of strengthening health systems: service delivery, health workforce, health information system and health research, essential medicines, health financing and leadership and governance, including health research;

PP9 While recognising the progress that has been made in attaining some of the health related MDGs many countries are not on track to fully attain some of the health related MDGs.

PP10 Cognizant of the high burden of communicable and the rising burden of Non-Communicable and Neglected Tropical Diseases exacerbated by poor nutrition and access to safe water and sanitation services and their devastating effects on the health of individuals and communities;

PP11 Recognising that inequitable access to quality health care, especially for women and children, continues to be an issue of major concern;

1. URGES Member States:

- (1) to ensure community empowerment and participation to attain the desired health outcomes;
- (2) to strengthen country ownership in articulating national plans and priorities and aligning efforts and resources;
- (3) to build towards sustainable progress on health outcomes through universal health coverage as an over-arching goal;
- (4) to honour their commitments towards agreed health targets and goals and take all necessary action to accelerate the attainment of the 2015 MDGs;
- (5) to fully engage on discussions on the post-2015 agenda to ensure that health is central to the development agenda and that universal health coverage (UHC) features prominently in the post-2015 agenda;
- (6) to strengthen all the dimensions of the six health system blocks assuring efficiency, effectiveness and equity;

2. CALLS UPON the Director-General:

- (1) to ensure that subsequent consultations on health in the post-2015 agenda continue to be inclusive at all levels and also well coordinated with other ongoing consultations;
- (2) to facilitate partnerships and more effective collaboration by different stakeholders as well as ensuring transparency and accountability;
- (3) to continue to mobilize financial and technical resources to enable Member States attain the 2015 MDG targets;
- (4) to further engage the High Level Committee on the post-2015 Agenda and the Office of the UN Secretary General to impress on the UN General Assembly the centrality of health in development.

Mr WANGDI (Bhutan) said that the primary goal of the post-2015 development agenda should be sustainable development for well-being and happiness for all. Good health was an important precondition for that, thus health should be a major focus. Noting that the particular concerns of small States – such as difficulties in the procurement of good-quality medicines, and the high cost of implementation – were often lost in the global arena owing to the small numbers of people affected, he asked that the post-2015 agenda reflected the concerns of small States, especially those that were landlocked.

Ms Jie-Ru TZENG (Chinese Taipei) said that all the other issues under consideration for inclusion in the post-2015 development agenda depended on health, and that more comprehensive consideration of health issues would therefore allow other problems to be better addressed. She supported the inclusion in the development agenda of human rights, participation, poverty eradication, equality and sustainability. Universal health coverage must play a key role, in conjunction with sustainable development and poverty reduction. Chinese Taipei was willing to share its own experiences of introducing universal health coverage.



Ms SCHULTZ (International Organization for Migration), speaking at the invitation of the CHAIRMAN, said that the post-2015 development agenda would need to address the health needs of the estimated 1000 million migrants worldwide, particularly women and child migrants, the undocumented and the lower-skilled. She emphasized that migrants' right to health had to be safeguarded in the light of the more restrictive policies on migrants' access to health care that were being considered in many countries; that guaranteeing migrants equitable access to health care and the inclusion of factors related to migrants and mobility in disease control programmes was necessary and cost-effective, improving public health outcomes; and that healthy migrants contributed to social and economic development and enhanced the well-being of their families and communities. Her organization wanted to see a focus on the underlying social determinants of migrants' health, and called for the inclusion of explicit indicators for monitoring their health in line with resolution WHA61.17 on health of migrants.

Ms SPELLER (Medicus Mundi International – International Organisation for Cooperation in Health Care), speaking at the invitation of the CHAIRMAN, said that identifying key lessons from the Millennium Development Goals was crucial if the post-2015 framework was not to replicate identified shortcomings. For example, measuring progress in terms of country averages had resulted in a failure to reflect the persistence of inequity and poor conditions of health among the poorest and most marginalized communities. The top-down process through which the Millennium Development Goals had been conceived and implemented had meant that questions of governance and participation had been insufficiently addressed. As those Goals had failed to address inequity in health, an increase in per capita income alone would not improve health outcomes without specific redistributive policies, and the achievement of equity within and between countries must therefore be a top priority in the new development agenda. The assumption that development could be achieved largely through the medium of international aid was an illusion that had diverted attention from the deeper and persistent political issues of structural imbalance. The prevailing "charity" model needed to be replaced by a human rights-based approach, with clearly delineated responsibilities and strong accountability mechanisms. The present day's global challenges merely touched on the surface of underlying problems, which meant that sustainable and equitable development – including governance reform and the restructuring of economic and political relationships – would be achieved only through new approaches to national and global decision-making, based on popular participation and direct democracy. The right to health would not be achieved unless the concept of development went beyond mere economic growth and industrialization.

Mr WRIGHT (The Save the Children Fund), speaking at the invitation of the CHAIRMAN, asked why the ambitious outcomes of the High Level Dialogue on Health organized by Botswana and Sweden were not yet reflected in the recommendations of the High-Level Panel, and suggested that the problem was that the access to private health care enjoyed in many countries by members of parliament and officials often made them disinclined to vote for systems that would compel them to contribute financially to the essential health care of the poor. Similarly, in a process that was dominated by governments of wealthy countries, the voices of the intended beneficiaries of development were not being heard. Thus the report of the High-Level Panel, which was due soon, marked the beginning of the process, not the end, and the subsequent process involving the Open Working Group on Sustainable Development Goals would strongly influence the goals that emerged. Stakeholders should ensure that their governments' and their people's voices were heard, as that was the only way to secure a global commitment to ambitious health targets aimed at reducing inequality and ending all preventable deaths.

Ms BARCLAY (International Planned Parenthood Federation), speaking at the invitation of the CHAIRMAN, expressed concern that the initial omission and then late inclusion in 2007 of sexual and reproductive health in the Millennium Development Goal framework had undermined progress, particularly towards Targets 5.A and 5.B. Low-income countries were disproportionately affected by

the lack of access to modern contraception, and the lives and opportunities of their people would continue to be compromised as a result. Family planning was one of the most cost-effective health and development interventions. Access to sexual and reproductive health services must be a basic building block of the post-2015 global development framework if it was to support sustainable social and economic growth and improve human well-being. The development framework must therefore include a specific target on sexual and reproductive health and rights, the continuation and expansion of Millennium Development Goal Target 5.B, and a stand-alone goal on gender equality and women's empowerment.

Ms EARDLEY (World Vision International), speaking at the invitation of the CHAIRMAN, called on Member States to ensure that health, particularly of the world's poorest women and children, remained central to the post-2015 development agenda. The current Millennium Development Goals ignored inequalities, and the post-2015 development agenda should therefore ensure that proven maternal, newborn and child health interventions targeted the poorest children and families. A high-level goal to end preventable maternal, newborn and child deaths was needed; articulating a goal for the universal extension of services or clustering maternal and child mortality alongside other health-related objectives would not be sufficient. Drawing attention to the recommendations of the United Nations Commission on Information and Accountability for Women's and Children's Health, she said that accountability should be enhanced by involving communities in the planning, monitoring and review of new health goals at all levels.

Miss DHATT (International Federation of Medical Students' Associations), speaking at the invitation of the CHAIRMAN, said that the construction of future development goals must be informed by the identified deficiencies of the Millennium Development Goals. She therefore called on Member States and the health community to champion the outcome report of the global thematic consultation on health; to press for the inclusion of health as a central theme in the post-2015 agenda and the incorporation of the principle of equity into all goals; and, in the context of the upcoming Open Working Group meetings, to engage with other sectors, in recognition of the multisectoral nature of global health. In the Millennium Development Goals, the best progress had been seen in those that were specific and measurable, which made it vitally important that at-risk populations such as young women and girls be specifically mentioned and that specific indicators be created. Monitoring of those indicators must be based on disaggregated data, as a means of ensuring that progress was equitable.

Dr KIENY (Assistant Director-General) said that the contributions made by delegates and representatives of civil society reflected the major progress made by many Member States towards the Millennium Development Goal targets but also highlighted the need for accelerated action to make more progress in the 934 days that remained until the end of 2015. Greater focus on areas that were lagging behind would be critical – including maternal mortality, sexual and reproductive health and rights, and adolescent health. Several speakers had emphasized the role of other sectors and of social determinants of health. She had noted the desire for the existing Millennium Development Goals that would not be attained to be a central part of the post-2015 agenda. Noncommunicable diseases and universal health coverage, including health systems strengthening, good-quality health services and financial risk protection, were also items to be included. Many interventions had highlighted the outcome of the global thematic consultation on health that had been facilitated by the Governments of Botswana and Sweden, UNICEF and WHO during the previous six months. That consultation had concluded with a high-level meeting in Botswana in March, and the report of the consultation had been submitted to the High-Level Panel of Eminent Persons on the Post-2015 Development Agenda that was to report to the United Nations Secretary-General. That report was a good basis for further engagement in the post-2015 development agenda, for instance as an input to the discussion of the Open Working Group on Sustainable Development Goals about positioning health in the overall development agenda and developing targets and indicators. The Secretariat was committed to continuing to work with Member States, civil society and other organizations in the United Nations

system on the post-2015 development agenda process, in order to ensure that health would occupy a central place.

The CHAIRMAN said that he took it that the Committee wished to suspend consideration of agenda item 14.1, pending the outcome of work by an informal drafting group convened to work further on the draft resolution that had been presented.

**It was so agreed.**

(For continuation of the discussion and approval of the draft resolution, see the summary record of the twelfth meeting, section 2.)

**Follow-up actions to recommendations of the high-level commissions convened to advance women's and children's health:** Item 14.2 of the Agenda (Documents A66/14 and EB132/2013/REC/1, resolution EB132.R4)

Dr ST. JOHN (Barbados, representative of the Executive Board) introduced resolution EB132.R4, entitled "Implementation of the recommendations of the United Nations Commission on Life-Saving Commodities for Women and Children".

**Dr Ross took the Chair.**

Dr THI HONG LUU (Viet Nam) said that her country had been actively implementing the recommendations of the Commission on Information and Accountability for Women's and Children's Health. The implementation of those recommendations would go hand in hand with Viet Nam's strategy on population/reproductive health 2011–2020, as part of the country's effort to achieve Millennium Development Goals 4 and 5 by 2015. Support from WHO and other partners would be welcome in that regard.

Ms STIRØ (Norway) said that initiatives under the United Nations Secretary-General's Global Strategy for Women's and Children's Health had led to landmark results in progress towards Millennium Development Goals 4 (Reduce child mortality) and 5 (Improve maternal health). A great deal remained to be done, however, and the collective commitment of the international community was still needed. The United Nations Commission on Life-Saving Commodities for Women and Children, co-chaired by Nigeria and Norway, had estimated that an ambitious scaling-up of 13 essential commodities would save more than 6 million lives over the coming five years. It had produced 10 recommendations for ensuring delivery of those commodities to people most in need and had listed practical proposals for eliminating the major hindrances to expansion of coverage and access to them. She strongly recommended that those proposals be put into action and welcomed the fact that an implementation plan developed to ensure rapid progress had already attracted considerable support. In the Abuja Ministerial Communiqué on the Implementation of the Recommendations of the Commission, a number of African countries had pledged to implement the recommendations adjusted to local needs and priorities. The Executive Board at its 132nd session had adopted resolution EB132.R4, which recommended a draft resolution for adoption by the Health Assembly, which she hoped it would do.

Dr KESKİNKILIÇ (Turkey) generally supported the draft resolution recommended in resolution EB132.R4 but expressed concern about two of the 13 recommended life-saving commodities listed in the annex to the draft resolution. First, misoprostol had been recommended for the control of postpartum haemorrhage but had not been licensed for that purpose by the European Medicines Agency or the United States Food and Drug Administration; and given that it was known to be used for medical abortion by health care professionals, it might give rise to other complications. Secondly,

antenatal corticosteroids, in view of concerns raised about the safety of their use during pregnancy, should be prescribed on a case-by-case basis. He therefore proposed that the words “under the supervision of health care professionals and” be inserted after “life-saving commodities” in subparagraph 1(1) of the draft resolution; and that the words “and the 13 life-saving commodities” in subparagraph 1(2) be deleted.

Dr ABHE (Côte d’Ivoire) said that Côte d’Ivoire was in the process of finalizing its country roadmap for strengthening accountability for women’s and children’s health, and that maternal, newborn and child health programmes had been mainstreamed into the national health accounts. Major challenges included strengthening the national health information system, monitoring and evaluating maternal and child health programmes, and increasing national resources for health. Further, the 13 recommended commodities listed in the annex to the draft resolution had been added to the list of essential medicines. Key concerns included frequent disruptions to the supply of essential products, insufficient funding to acquire those products and a lack of training for service providers in their use.

Mr ÁLVAREZ LUCAS (Mexico) reiterated his country’s endorsement of the recommendations of the Commission on Information and Accountability for Women’s and Children’s Health and agreed with the assessment in document A66/14 of the barriers hindering access to the 13 commodities recommended by the United Nations Commission on Life-Saving Commodities for Women and Children. Mexico was already working to implement the latter’s recommendations, especially with regard to the quality and availability of those commodities, particularly to the most vulnerable groups.

Dr AL-TAAE (Iraq), stressing the importance of attaining Millennium Development Goals 4 and 5 in paving the way towards achievement of the other Goals, said that the related indicators should be aligned with priorities in regard to reproductive and maternal and child health services according to each country’s epidemiological and demographic data. Particular emphasis should be placed on monitoring growth, combating malnutrition and promoting immunization in coordination with the Integrated Management of Childhood Illnesses strategy, with breastfeeding regarded as a child’s first dose of immunization. Relevant programmes must be incorporated into primary health care, centring on evidence-based practices in family medicine and family health services.

Dr DA COSTA SARMENTO (Timor-Leste) said that her country supported implementation of the recommendations of the Commission on Information and Accountability for Women’s and Children’s Health through its country accountability framework. Timor-Leste was strongly committed to achieving Millennium Development Goals 4 and 5, and she urged the Secretariat to work with Member States and partners to provide the technical support needed to ensure the quality of essential medicines and life-saving commodities. Quality information for civil registration and vital statistics systems, results monitoring and review systems was essential.

Timor-Leste was ready to carry forward the recommendations of the United Nations Commission on Life-Saving Commodities for Women and Children; to support the availability and quality of relevant raw materials and products through capacity-building for prequalification; and to define regulatory pathways to eliminate the impediments to expansion of coverage with and access to recommended commodities. In the area of reproductive health, however, the recommendation on emergency contraception could not be implemented in her country or countries that had introduced anti-abortion legislation.

Dr CARTIER (Belgium), also speaking on behalf of the Netherlands, strongly supported the draft resolution and requested the Secretariat to step up efforts to stimulate research, to promote best practices in low-income countries and to update the reproductive health strategy, in order to accelerate progress towards attainment of international development goals.

**Dr Gwenigale resumed the Chair.**

Dr GOYITO (Benin), speaking on behalf of the Member States of the African Region, said that African countries were committed to stepping up their response to the United Nations Secretary-General's Campaign for Accelerated Reduction of Maternal Mortality. Each, in its efforts to achieve the Millennium Development Goals, had carried out self-assessment of its current situation concerning accountability for health through the monitoring of results, tracking of resources and strengthening of civil registration and vital statistics systems, as well as through maternal mortality surveillance and response, and advocacy for accountability. Given that maternal, child and youth mortality in the African Region was among the highest in the world, the implementation of accountability roadmaps should involve the concerted efforts of all stakeholders, including local and national governments, research institutions, civil society and nongovernmental organizations. New funding mechanisms should be developed, aid should be better coordinated and strategies should be developed to strengthen health systems, with a particular emphasis on human resources for service provision, monitoring and evaluation.

Dr DIAZ ANAÍZ (Chile) said that his Government supported the work being done by WHO to help countries meet their commitments to attain the Millennium Development Goals in relation to child mortality and maternal health. Reproductive health services in his country, including monitoring during pregnancy and childbirth, family planning and the prevention of sexually transmitted diseases, had brought about significant reductions in maternal and perinatal morbidity and the incidence of miscarriage. He supported the draft resolution.

Professor PRASAD (India) said that his Government's five-year plan (2012–2017) placed particular emphasis on the promotion of health sector governance and accountability, which was critical for monitoring outputs and outcomes following significant increases in health expenditures. India was one of the six countries in the South-East Asia Region involved in developing the country accountability frameworks and roadmaps recommended by the Commission on Information and Accountability for Women's and Children's Health, and work was in progress. Bearing in mind the importance of intersectoral coordination, the Government was preparing to finalize a roadmap aimed, inter alia, at implementing a nationwide accountability framework adapted to the country's specific needs and priorities; strengthening the health management information system and national health accounts; and scaling up the civil registration and vital statistics system. India endorsed WHO's proposed actions to follow up on the Commission's recommendations.

Dr ALZAYANI (Bahrain), speaking on behalf of the Member States of the Eastern Mediterranean Region, reported that eight of the 10 countries in the Region identified by the Commission on Information and Accountability for Women's and Children's Health had already conducted training and established roadmaps and country plans. Implementation of the roadmaps would contribute greatly to WHO's initiatives to accelerate progress towards attainment of Millennium Development Goals 4 and 5. Joint efforts were needed, drawing on global, regional and national expertise, in order to ensure that every country had the capacity to meet their commitments and to operationalize the recommended accountability frameworks. WHO should also work with partner agencies on scaling up coordinated support, including in the area of policy-making; expand access to quality interventions and life-saving commodities, and on continuing to strengthen health information systems, to improve maternal and child mortality data for more effective monitoring of impacts and changes. The Member States in the Region supported the draft resolution.

Dr USHIO (Japan) said that it was important to examine and discuss ways to tackle the bottlenecks hindering progress in providing women and children in resource-limited settings with access to life-saving commodities. Even though the Independent Expert Review Group would play a major role in monitoring progress at the global level, an effective evaluation system would be essential to clarify the roles and responsibilities of the many different agencies and partners involved in country-level monitoring, and to assess the achievements and challenges of initiatives such as the

Every Woman Every Child movement in efforts to attain Millennium Development Goals 4 and 5. With just two years remaining before the deadline, increased coordination was needed for Member States and international partners to implement the recommendations of the two high-level commissions.

Dr PABLOS-MENDEZ (United States of America) said that his country worked closely with international partners to increase the availability and rational use of quality-assured commodities for women and children, and was especially encouraged by the success achieved in many developing nations. At the Child Survival Call to Action high-level forum, held recently in Washington DC on 14 and 15 June 2012, representatives of countries from all over the world had come together to renew their commitment to ensuring that every child, no matter where born, enjoyed a healthy and secure start in life. A comprehensive women-centred approach would ensure that every woman was aware of and had access to the tools and services needed to maintain her health and that of her children. He supported the draft resolution.

Professor ARSLAN (Bangladesh) said that his country was actively engaged in implementing the recommendations of the Commission on Information and Accountability for Women's and Children's Health and, with technical support from WHO, had already prepared its country accountability framework. Considerable progress had been made in the area of eHealth and the use of information and communication technologies in the national health system, with all stakeholders from the national to the grassroots level being interlinked through a common Internet-based platform. The eHealth backbone would serve to register and monitor every pregnant woman and every child under five years of age and would use the Commission's 11 indicators in real time to track progress towards attainment of Millennium Development Goals 4 and 5. Meanwhile, Bangladesh was also following up on the recommendations of the Independent Expert Review Group and the United Nations Commission on Life-Saving Commodities for Women and Children. He supported the draft resolution.

Dr DAKULALA (Papua New Guinea) said that his Government had been particularly interested in the report in view of its own work in the area of accountability, including a pilot project and model to improve child health service delivery and outcomes. He welcomed the various high-level initiatives aimed at accelerating progress towards Millennium Development Goals 4 and 5, including the Child Survival Call to Action to which his country was a signatory. He acknowledged the significant financial and technical support received from WHO and multiple donors over the years, but said that the prioritization of child health had been inadequate, meaning that the country's accountability initiative lacked donor support that was balanced and aligned with the country's real needs. He supported the adoption of the draft resolution, taking into account the concerns expressed and amendments proposed by the delegate of Turkey.

Dr CHOMPOONUT THAICHINDA (Thailand) acknowledged the recommendations of the United Nations Commission on Life-Saving Commodities for Women and Children and welcomed the draft resolution. In view of the financial barriers hindering access to those commodities by the poorest members of society, however, and reiterating the importance of universal health coverage as a means of achieving equity and reducing poverty, she proposed that subparagraph 1(3) of the resolution be amended to read: "providing universal access to all members of society, regardless of their ability to pay, to have access to the 13 life-saving commodities and any other appropriately related commodities;".

Ms CHUNG (Canada) said that Canada remained committed to supporting implementation of the recommendations of the Commission on Information and Accountability for Women's and Children's Health and, welcoming WHO's continued leadership in the field, she encouraged all Member States and partners to do likewise. Canada also supported implementation of the recommendations of the United Nations Commission on Life-Saving Commodities for Women and

Children, calling for increased coordination among the two commissions and all of the initiatives under the United Nations Secretary-General's Global Strategy for Women's and Children's Health.

Dr AFZAL (Pakistan) acknowledged the fact that Pakistan, as one of the 10 countries in the Eastern Mediterranean Region with a high burden of maternal and child mortality, had a strong need to strengthen its essential maternal, newborn and child health services. Workshops had been held to consolidate provincial roadmaps into a single national roadmap identifying costed and priority actions for the period 2013–2015, and a model had been introduced to quantify needs with respect to the supply of contraceptives. Further technical collaboration with WHO and its partners would be highly appreciated. She supported the draft resolution.

Ms WENDLING (Germany) said that more rapid progress towards the Millennium Development Goals depended on better access to quality health services for women and children, which would remain a priority of her country's development cooperation. In view of the importance of providing affordable and effective life-saving commodities, especially for newborn infants, she supported the draft resolution. Its adoption would help to implement the United Nations Secretary-General's Global Strategy for Women's and Children's Health, to which Germany was fully committed.

Professor BAGGOLEY (Australia), stressed that access to the 13 life-saving commodities recommended by the United Nations Commission on Life-Saving Commodities for Women and Children was the key to reducing maternal and child mortality and to achieving the Millennium Development Goals, and that timely and adequate distribution of such commodities was crucial in the Asia-Pacific region, where supply difficulties had a major impact on health care delivery. He therefore urged the Health Assembly to adopt the draft. Australia had been closely involved in the Child Survival Call to Action and at the London Summit on Family Planning had pledged to double its expenditure on family planning programmes.

Dr ESCARTIN (Philippines) said that his country was committed to implementation of the United Nations Secretary-General's Global Strategy for Women's and Children's Health. The Government sought to ensure the safety of mothers and their children during pregnancy and childbirth through the provision of quality emergency obstetrics and newborn care in primary health care facilities and access to life-saving commodities, backed by universal health insurance coverage for the poor. It also provided funding for contraception and was preparing to enact a law on responsible parenthood and reproductive health, which would serve as a springboard for a national maternal and child health programme.

Dr MWINYI (United Republic of Tanzania), underlined his country's commitment to continuing to strengthen information accountability for women's and children's health. He commended WHO's support for the development of country frameworks; the significant progress made on the associated workplans was encouraging.

Regarding the recommendations of the United Nations Commission on Life-Saving Commodities for Women and Children, he proposed that the words "and other essential commodities for reproductive, maternal, newborn and child health" be inserted into two subparagraphs of the draft resolution: subparagraph 1(1), between "13 life-saving commodities" and "and building upon"; and subparagraph 1(3), in place of "and any other appropriately related commodities". The United Republic of Tanzania supported the adoption of the draft resolution, as amended.

Ms JAMEEL (Maldives) said that her country, in spite of the challenges faced in delivering health care services to a population spread across more than 1000 islands, had already attained Millennium Development Goals 4 (Reduce child mortality) and 5 (Improve maternal health), and was taking measures to sustain those achievements. She stressed the importance of educating not only

health service professionals but also the community, especially its most vulnerable groups, on the commodities listed in the resolution, as to availability, right to use and methods of use. She agreed with the comments of the delegate of Thailand concerning financial barriers, emphasized the importance of universal health coverage and requested continued support from WHO and other development partners.

Dr KAMALIAH MOHAMAD NOH (Malaysia) said that the 10 recommendations of the Commission on Information and Accountability for Women's and Children's Health would assist countries in evaluating and monitoring progress through systematic self-assessment of their current situation. Noting the recommendations of the United Nations Commission on Life-Saving Commodities for Women and Children, she said that her Government's national medicines policy sought to ensure adequate, equitable and continuous access to safe and effective, high-quality, essential medicines for the entire population. She endorsed the draft resolution.

Dr IMRAN PAMBUDHI (Indonesia) expressed appreciation to the Secretariat for the report, which was of particular importance to his country in its continuing struggle to achieve the Millennium Development Goal targets on maternal and neonatal mortality. With regard to the maternal health commodities recommended by the United Nations Commission on Life-Saving Commodities for Women and Children, he pointed out that misoprostol was registered in his country for the treatment of gastric ulcer, not postpartum haemorrhage, for which oxytocin and magnesium sulphate were already established as the essential medicines in Indonesia. His Government was committed to using the WHO guidelines on newborn cord care, and he requested that guidelines on postpartum haemorrhage and management of newborn care be improved using an evidence-based approach.

Dr RODRÍGUEZ (El Salvador) said that her country's health reform and network of integrated health services had led to significant improvements in maternal and child health in line with the recommendations of the two high-level commissions, which El Salvador supported fully. She expressed appreciation for the support of WHO and in particular of the Pan American Health Organization, through the Safe Motherhood initiative, which had contributed to reducing both maternal and infant mortality, to increased antenatal care and to skilled attendance at births.

Mr SHI Guang (China) endorsed all the recommendations of the Commission on Information and Accountability for Women's and Children's Health, stressing that establishing an efficient and transparent accountability framework was key to implementation of the United Nations Secretary-General's Global Strategy for Women's and Children's Health. His Government attached great importance to the construction of information systems for the surveillance of maternal health and mortality. It was currently developing an accountability framework for self-evaluation of its national situation to ensure progress towards achievement of the Millennium Development Goal on maternal health. China was ready to reinforce international cooperation and to share its experience.

China endorsed the 10 recommendations of the United Nations Commission on Life-Saving Commodities for Women and Children, suggesting that Member States should undertake relevant technical training; that guidelines should be developed for equitable access to and correct use of the 13 recommended commodities, as well as for their supply to poverty-stricken areas; and that WHO and its partners should play a more active role in providing technical support.

Dr HABTEMARIAM (Ethiopia) drew attention to the importance of health system strengthening for delivering maternal and child health services, and to the need for resource tracking and partnership to improve health outcomes. Ethiopia supported the efforts of WHO and its partners and called for greater emphasis on alignment and harmonization among plans.



Dr TESFAZION (Eritrea) drew attention to some of the strategies adopted in his country to tackle maternal and newborn mortality, including the establishment of maternity clinics in remote areas; health system strengthening; the development of a country roadmap for strengthening accountability; the elaboration of guidelines and training manuals on integrated management of neonatal and childhood illnesses, sexual and reproductive health and the treatment of women of child-bearing age; and the preparation of documentation on best practices. Such strategies had established Eritrea as one of the countries of his Region that were on track towards achieving the relevant Millennium Development Goals. He fully supported the initiative of identifying the 13 life-saving commodities listed in the annex to the draft resolution.

Dr LOKADI OTETE OPETHA (Democratic Republic of the Congo) said that his Government had organized a series of workshops to promote national adoption of the recommendations of the high-level commissions, had developed a plan to accelerate the country's progress towards Millennium Development Goals 4 and 5, and had incorporated the 13 recommended life-saving commodities into its list of essential medicines. A national consensus had been reached on the commodities; precautionary measures had been taken to enhance on-the-ground supervision so as to ensure their correct use; and arrangements had been made with the support of UNICEF to conduct a pilot project in five districts before their general introduction. He requested WHO to continue advocacy for increased mobilization of the 13 commodities and to pursue its work in the field of human capacity-building and coordination. He supported the draft resolution.

Dr WAPADA (Nigeria) said that Nigeria, as Co-Chair of the United Nations Commission on Life-Saving Commodities for Women and Children, strongly endorsed the draft. A national social protection framework was being developed to guide the efforts of stakeholders in his country; mechanisms were being put in place to remove financial barriers to women's and children's access to health care services; and steps were being taken to mainstream gender issues into policy-making and programming in the health sector, among others.

Dr RAMOKGOPA (South Africa) highlighted the need to strengthen national health systems with the inclusion of primary health care services and referral systems, and to ensure the availability of human resources for health, with the recommended training. South Africa was co-convening an international conference on maternal and child health with the African Union, to be held in August 2013, with a view to taking stock of progress and developing measures to accelerate improvements. She invited WHO to provide the necessary technical support.

Dr CLAURE (Plurinational State of Bolivia) said that his country was committed to achieving the health-related Millennium Development Goals and that increased public spending on the health system and the recruitment of medical and paramedical professionals, especially at the primary health care level, had led to significant reductions in maternal and under-five child morbidity and mortality. The Government, having decided to step up its support and to extend services in the near future to the whole population, was seeking external support, which should respect local customs and national sovereignty, in order to facilitate its work and further progress towards the Goals.

Ms MARTHOLM FRIED (Sweden) agreed with most of the amendments proposed. With regard to the amendment to subparagraph 1(1) proposed by the delegate of Turkey, however, she said that not all of the 13 life-saving commodities would need to be used under the supervision of health-care professionals and suggested that the new text be amended to read: "under the supervision and guidance of health care professionals, where needed". Once that suggestion had been taken into account, she would be ready to adopt the draft resolution, as amended.

Monsignor VITILLO (Holy See), speaking at the invitation of the CHAIRMAN, expressed grave concern about the reference in the report to the scaling up of access to “emergency contraception”. It was unacceptable to encourage the increased use of abortifacient substances and to describe them as “life-saving commodities” when they constituted a direct attack on the life of the child in utero. The Holy See did not regard abortion or abortion services as a dimension of reproductive health and it urged the international public health community to focus its attention and resources on measures in the report that defended and preserved life at all stages, including in utero.

Ms Yu-Hsuan LIN (Chinese Taipei) said that Chinese Taipei placed great emphasis on the holistic promotion of women’s and children’s health through policies including the provision of prenatal examinations; health insurance coverage for delivery expenses; screening for congenital anomalies and diseases leading to premature births and low birth weight; and voluntary reporting of such cases to provide appropriate follow-up health care services. Chinese Taipei, which had the 20th lowest infant mortality rate in the world, was ready to share its experience with all Member States and health authorities.

Ms UPLEKAR (International Alliance of Women), speaking at the invitation of the CHAIRMAN and also on behalf of the International Federation of Business and Professional Women, welcomed the progress outlined in the report with regard to the recommendations of the two high-level commissions. She expressed satisfaction that most of the 75 countries where 95% of maternal and child deaths occurred had carried out a systematic self-assessment of their current situation as to accountability for health, adding that countries lagging behind should be encouraged to join the majority without delay. She also called for the rapid scaling-up of access to emergency contraception and other relevant interventions. Countries where sexual abuse was most prevalent must improve information and accountability at every level of society, where appropriate by harmonizing traditional legal norms with international human rights.

Ms O’SHEA (World Vision International), speaking at the invitation of the CHAIRMAN, stressed the importance of harmonizing implementation of the recommendations of the United Nations Commission on Life-Saving Commodities for Women and Children with other relevant initiatives, such as the integrated Global Action Plan for the Prevention and Control of Pneumonia and Diarrhoea and the forthcoming Global Newborn Action Plan; and of encouraging world leaders to commit funding to support national implementation plans. The progress made in implementing the recommendations of the Commission on Information and Accountability for Women’s and Children’s Health was encouraging, but only 25 country roadmaps had been completed by the end of 2012. Particular emphasis should be placed on community involvement in planning, monitoring and evaluation, as that could play a key role in improving service delivery and health outcomes, backed by the establishment or strengthening of accountability mechanisms at the local level. World Vision International commended the Independent Expert Review Group’s transparent and inclusive work to date in reaching out to stakeholders and encouraging the meaningful participation of civil society.

Miss DHATT (International Federation of Medical Students’ Associations), speaking at the invitation of the CHAIRMAN, noted the absence of young people from the current debate on advancing women’s and children’s health. She called on Member States, as they determined young people’s immediate future, to consider recommendations such as ensuring access to secondary education; setting the minimum legal age for marriage at 18 years; guaranteeing the sexual and reproductive rights of young people, and mainstreaming those rights into youth-friendly primary health care for all, especially the most vulnerable populations; and ensuring that the voices of youth were heard in the debate on women’s and children’s health and welfare. The Secretariat should follow the example set by the United Nations Secretary-General in proposing to engage with young people, and Member States should include youth representatives as active members of their delegations.

(For continuation of the discussion and approval of the draft resolution, see the summary record of the seventh meeting, section 1.)

### **3. ORGANIZATION OF WORK**

The CHAIRMAN announced that, according to the agreement by the General Committee on the allocation of work to the main committees,<sup>1</sup> and following consultation between the vice-chairmen of Committees A and B and the President of the Health Assembly, item 17 (Health systems) and item 18 (Progress reports) would be transferred to the agenda of Committee B. The latter Committee would begin its consideration of item 17 by discussing item 17.3, Universal health coverage.

**It was so agreed.**

**The meeting rose at 12:05.**

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<sup>1</sup> See the summary record of the second meeting of the General Committee, section 2.

## SEVENTH MEETING

Thursday, 23 May 2013, at 14:35

**Chairman:** Dr W.T. GWENIGALE (Liberia)

### **1. PROMOTING HEALTH THROUGH THE LIFE COURSE:** Item 14 of the Agenda (continued)

**Follow-up actions to recommendations of the high-level commissions convened to advance women's and children's health:** Item 14.2 of the Agenda (Documents A66/14 and EB132/2013/REC/1, resolution EB132.R4) (continued from the sixth meeting, section 2)

Dr BUSTREO (Assistant Director-General), responding to comments made during the sixth meeting, thanked delegates for the information provided on their countries' efforts to advance women's and children's health. Their comments revealed the commitment and interest demonstrated by governments since the launch of the United Nations Secretary-General's Global Strategy for Women's and Children's Health. She noted with appreciation the work carried out by the President of Nigeria and the Prime Minister of Norway and their Governments and their leadership of the United Nations Commission on Life-Saving Commodities for Women and Children.

In the previous two years there had been a surge in commitment and in action to address women's and children's health, as demonstrated by the initiatives to save the lives of mothers and children in the Eastern Mediterranean Region referred to by the delegate of Lebanon. There had also been increased commitment in the African Region, as exemplified by the accelerated campaign for reduction of maternal mortality under the leadership of the African Union.

She had noted the comments made in relation to the recommendations of the Commission on Life-Saving Commodities and wished to assure Member States that the Secretariat would work with other agencies and partners to advance the necessary regulatory work and the inclusion of those commodities in guidelines and training modules for health workers. The Secretariat would also work with governments on adjusting their policies and ensuring that they had the information they needed for policy debates.

Many delegates had highlighted the need for increased coordination and synergies among the various initiatives that had emerged from the global strategies for women's and children's health. The independent Expert Review Group on Information and Accountability for Women's and Children's Health had similarly recommended that the global governance framework for women's and children's health should be strengthened, and WHO and its sister agencies in the Health 4+ (H4+) partnership were working to put in place an improved coordination mechanism to ensure better and more transparent use of resources mobilized for women's and children's health. She acknowledged that in order to access quality commodities, action to strengthen health systems was required, in particular with respect to the human resources needed to deliver those commodities.

Responding to requests for guidance from several Member States, she recalled that revised guidelines on the prevention and treatment of postpartum haemorrhage<sup>1</sup> had been published in 2012. The guidelines addressed the use of misoprostol and other uterotonic drugs. With regard to the request

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<sup>1</sup> WHO recommendations for the prevention and treatment of postpartum haemorrhage. Geneva: World Health Organization; 2012.

to update the global strategy on reproductive health, the Secretariat would provide the evidence that underpinned the strategy.

The CHAIRMAN invited delegations to consider the draft resolution contained in resolution EB132.R4. He requested the Secretary to read out several amendments that had been submitted.

Dr ARMSTRONG (Secretary) said that amendments to subparagraphs 1(1), 1(2) and 1(3) had been proposed. As amended, subparagraph 1(1) would read: “improving the quality, supply and use of the 13 life-saving commodities and other essential commodities for reproductive maternal, newborn and child health under the supervision and guidance of health care professionals, where needed, and building upon information and communication technology best practices for making these improvements”; subparagraph 1(2) would read: “developing plans to implement at scale appropriate interventions to increase demand for and utilization of health services, particularly among underserved populations”; and subparagraph 1(3) would read: “providing universal access to all members of society, regardless of their ability to pay, to have access to the 13 life-saving commodities and other essential commodities for reproductive maternal, newborn and child health”.

Mr KOLKER (United States of America) said that he would prefer the word “facilitating” to “providing” in subparagraph 1(3) and proposed that the reference to “the poorest members of society” should be reinstated and the words “regardless of their ability to pay” should be removed, as they might give the impression that Member States would provide the commodities free of charge. Subparagraph 1(3) would then read: “addressing financial barriers to ensure the poorest members of society have universal access to the 13 life-saving commodities and other commodities for maternal, newborn and child health;”.

Ms HARB (Lebanon) suggested that subparagraph 1(3) should begin: “provide universal access to the poorest members of society” and end with the words: “and facilitate access, regardless of ability to pay, to all 13 life-saving commodities and any other appropriately related commodities”.

Mr KOLKER (United States of America) enquired whether the original amendment proposed by Thailand had included the words “addressing financial barriers”. In his view, that wording should be retained.

Dr CHOMPOONUT THAICHINDA (Thailand) said that the amendment proposed by her delegation had read: “providing universal access to all members of society, regardless of their ability to pay, to access to the 13 life-saving commodities ...”; however, her delegation would accept the proposal by the delegate of the United States of America to replace “providing” with “facilitating” and to delete the words “regardless of their ability to pay”.

The CHAIRMAN noted that the delegate of Lebanon had requested that the words “regardless of their ability to pay” be retained. He sought the assistance of the Committee in crafting wording that would convey the idea that the poor would not be denied access to the commodities because of inability to pay without also giving the impression that no one would be expected to pay for them.

Mr KOLKER (United States of America) said that the wording proposed by the delegate of Thailand was acceptable to his delegation.

Ms HARB (Lebanon) proposed that subparagraph 1(3) should read: “providing universal access to ensure the poorest members of society and facilitating access to all other members, regardless of ability to pay, to the 13 life-saving commodities ...”.

Ms STIRØ (Norway) suggested that subparagraph 1(3) might read: “facilitating universal access for all members of society, in particular the poorest, to the 13 life-saving commodities ...”.

Mr KOLKER (United States of America), Ms HARB (Lebanon) and Dr CHOMPOONUT THAICHINDA (Thailand) indicated their acceptance of the wording suggested by the delegate of Norway.

The CHAIRMAN said that he heard no objections and therefore he took it that the Committee wished to approve the draft resolution, as amended.

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

Dr PODESTA (Malta), speaking in explanation of its position, said that, while Malta was wholly committed to the overall goal of the resolution, her delegation would nevertheless like to register its reservation regarding the inclusion of emergency contraception as one of the commodities advocated by the Commission as a means of enhancing the health of women and children. Her Government held the view that human life began at conception, and under the national legislation of Malta the termination of pregnancy through induced abortion at any stage of gestation was illegal; neither abortion nor emergency contraception was legally recognized as a family planning method. Consistent with that legislation, her delegation affirmed its reservation with respect to the resolution’s reference to emergency contraception and any other provision that directly or indirectly related to induced abortion.

**Social determinants of health:** Item 14.3 of the Agenda (Document A66/15)

Professor DILMEN (Turkey) said that continuous efforts to strengthen health systems and address social determinants of health were needed if Member States were to reach the goal of ensuring the highest attainable standard of health for their populations. Intergovernmental cooperation both in the policy sphere and in practice was also important, as were multisectoral collaboration and research aimed at identifying practices and problems, such as unfair resource allocation, that affected health status. He appreciated the work done by the Secretariat at headquarters and the regional offices in raising awareness among policy-makers of the importance of including social determinants of health in their national health policies. His Government was committed to shaping its health policies so as to reduce economic, geographical and social inequities and had made good progress towards reducing gaps between population groups with regard to health and development outcomes. Its achievements augured well for future collaborative work within the Government and for more planned, systematic and strategic work to address social determinants of health. Turkey stood willing to collaborate with WHO on multisectoral health programmes with a view to strengthening its capacity to monitor and evaluate progress and sharing its experience with other countries.

Ms BIKISSA NEMBÉ (Gabon), speaking on behalf of the Member States of the African Region, said that the report highlighted the potential of social determinants of health to catalyse concerted effort to accelerate progress towards the Millennium Development Goals before 2015. The preparation of a global workplan to address the five action areas of the Rio Political Declaration on Social Determinants of Health would enable all stakeholders to address the challenges associated with social determinants of health, including health inequalities. The plan could only be implemented, however, if national capacities were significantly strengthened in the areas of good governance, human resources, health information, health research, and development of guidelines and tools for follow-up and evaluation of activities related to social determinants of health.

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<sup>1</sup> Transmitted to the Health Assembly in the Committee’s third report and adopted as resolution WHA66.7.

Dr LUCO (Chile) said that her country's national health strategy for 2011–2020 was in line with the commitment it had made under the Rio Political Declaration to develop inclusive policies that took account of the needs of the entire population, with specific attention to vulnerable groups and high-risk areas. The strategy recognized that health status and illness had social determinants that must be addressed through multisectoral policies and action by both public- and private-sector actors. It had guided the development of intersectoral policies on ageing, health inequalities and other issues, with emphasis on health promotion and disease prevention and strengthening of primary health care. Also in line with Chile's commitment under the Rio Political Declaration to promote participation in policy-making and implementation, young people were being involved in the development of plans and programmes. Their active participation had been key to identifying the health problems that affected them and designing policies to address those problems. The value of youth participation in policy-making was evident in the decline in adolescent pregnancies.

Dr VALDEZ (Philippines) said that the Philippines recognized the importance of integrating social determinants in all health initiatives and saw the value of engaging both local and international stakeholders in the implementation of the Rio Political Declaration. His Government was applying a health-in-all-policies approach to the prevention and control of noncommunicable diseases, bringing together representatives from other government agencies, nongovernmental organizations, the private sector and civil society groups. In order to institutionalize the approach and ensure that social determinants were taken into account in all government policies, support would be required from WHO for training and facilitation of collaborative exchange programmes with expert institutions in order to further research on social determinants of health. The development of a tool to gather and compare case studies would enable the Philippines to share its strategies for addressing health determinants and to learn from other Member States. The establishment of health observatories at the subregional and local levels would also be useful.

Dr AFZAL (Pakistan) said that, because most social determinants of health originated outside the health sector, it was essential to engage actors outside government, especially in civil society, in order to ensure sustainability through social participation and ownership. Recognizing the cross-cutting nature of social determinants of health, Pakistan had taken significant steps to incorporate them into policies and strategies, raise their profile and that of health equity, identify key social determinants and challenges for health inequity and develop an institutional framework to address them.

Dr SAENGNAPHA UTHAISANGPHAISAN (Thailand) observed that the issue of social determinants of health was closely related to health in all policies, health impact assessments, health equity and universal health coverage. WHO should work with Member States and other United Nations agencies to ensure that health targets were properly reflected and included in the post-2015 development goals. Once health targets had been established, it would be imperative for Member States and the Secretariat to provide strong support to strengthen basic health infrastructures, human resources for health and access to essential medicines. Gatherings such as the 8th Global Conference on Health Promotion (Helsinki, Finland, 10–14 June 2013) and the 21st International Union for Health Promotion and Education (IUHPE) World Conference on Health Promotion (Pattaya, Thailand, 25–29 August 2013) would help to keep social determinants of health and health in all policies high on the global development agenda and to translate concepts into concrete practices.

Mr CONSTANT (Trinidad and Tobago), speaking on behalf of the member countries of the Caribbean Community, said that the Rio Political Declaration had helped to focus intersectoral and interministerial attention on the social determinants of health. Many governments in the Caribbean subregion had established multisectoral committees to implement the Declaration and had developed national action plans that advocated a health-in-all-policies approach. The emphasis on collaboration and systemic engagement with other sectors was expected to reduce health inequities, improve living

conditions and lead to a more equitable distribution of power, money and resources. Emphasis had also been placed on monitoring and evaluation of projects and programmes in order to assess their impacts. An integrated approach was needed in order to address health inequities effectively. Countries in the Caribbean subregion had benefited from and were grateful for the global integrative approach facilitated by WHO, PAHO and others and requested continued support, especially through training, in order to build capacity to act on social determinants of health. Social determinants of health must be part of the post-2015 development agenda.

Dr KAMALIAH MOHAMAD NOH (Malaysia) said that Malaysia recognized the important effects of social determinants on the population's overall health outcomes and health status. WHO should continue to work closely with other international agencies and Member States in order to strengthen social protection for health, especially for vulnerable populations. Because many health determinants fell outside the purview of the health sector, it should also facilitate more forums to promote intersectoral collaboration.

Dr OLLILA (Finland), welcoming the inclusion of social, economic and environmental determinants of health in the Twelfth General Programme of Work, stressed that action on health determinants would require a critical mass of knowledge and capacities, both in countries and within the Secretariat. Addressing the social determinants of health would also require action on health systems and the promotion of policies in other sectors that would protect and promote health and health equity. Cross-cutting policies were particularly important in times of austerity in order to limit the negative impacts of the economic crisis. Even more important was a sustained focus on health inequalities and on ensuring equity in access to health care. Health-in-all-policies approaches offered a means of strengthening action on the social determinants of health and would be further explored at the 8th Global Conference on Health Promotion.

Ms BELL (Canada) said that health outcomes in Canada were good and continued to improve although health inequalities persisted and, in some cases, were growing, especially among Canada's indigenous peoples, low-income populations and those living in the north of the country. The Government would continue to invest in health and social support, explore new and innovative approaches and engage in intergovernmental and intersectoral action in order to address the social determinants of health. Canada looked forward to the development of the reporting approach for the Rio Political Declaration and to the presentation of the WHO report on the subject at the Sixty-eighth World Health Assembly. It would also welcome opportunities to learn about global best practices and to collaborate with the Secretariat and other Member States in order to advance the Rio commitments.

Dr AL HINAI (Oman) said that Oman monitored most social determinants of health by means of regular reports and surveys. As health was a shared responsibility, all sectors should join forces to enhance the quality of life of all members of society. National capacity-building was required in the various action areas covered by the Rio Political Declaration. Oman was committed to the principles set forth in the Declaration and to its implementation. She called for greater technical cooperation and the sharing of expertise in developing indicators that could be used in monitoring and assessing social determinants of health.

Mr SHI Guang (China) said that China had always been an active participant in and advocate for studies on social determinants of health. The Government had recently signed a national strategic cooperation agreement with WHO, which provided for collaboration with other sectors and for promotion of health in all policies. WHO should continue to support Member States in building capacity, strengthening cooperation and sharing experiences, knowledge dissemination, technological development and policy support in relation to social determinants of health. Greater attention needed to be paid to health determinants in order to reduce health gaps and promote sustainable development; they should therefore be given prominence within the post-2015 development agenda.



Mrs CARTER TAYLOR (Barbados) said that the Government of Barbados had entered into a formal social partnership with the private sector and labour unions in order to advance sustainable and economically manageable social development that would ensure that improvements in health status were maintained. It stood ready to share its experience with others. She noted the development of tools and web-based applications to support capacity-building and encouraged their sharing among WHO Member States.

Dr AL-TAAE (Iraq) said that social determinants of health could be promoted through intersectoral collaboration and community participation, in order collectively to improve the health status of populations and thus contribute to the achievement of the Millennium Development Goals. In line with the Rio Political Declaration, Iraq had embraced an approach that recognized that community development was a prerequisite for health development and that reaffirmed the importance of primary health care. All strategic workplans should incorporate indicators relating to social determinants of health.

Dr VALLEJO (Ecuador) said that the report should have contained more references to progress on social determinants of health in the Region of the Americas, and especially in Latin America and the Caribbean, where many ideas and much of the discussion on the topic had originated. Referring to the section in the report on collaboration within the United Nations system, he emphasized that WHO should collaborate not only with traditional partners such as those mentioned in paragraph 23, but with organizations outside the health sphere, such as WTO and FAO. The involvement of such organizations in efforts to address social determinants of health was essential. Lastly, he highlighted the importance of health-in-all-policies approaches. Ecuador had made significant progress in reducing health inequities by introducing such an approach and would be sharing its experiences in that regard at the 8th Global Conference on Health Promotion.

Mr KLEIMAN (Brazil) noted that there was consensus on the need to promote health in all policies and foster intersectoral action, since health could not be improved by the health sector working in isolation. It was impossible to speak of social determinants of health without also speaking of the development model being pursued at the global level and of the role that health should play in the development agenda post-2015 and beyond. Governments and the Secretariat should promote greater involvement of society in the debate on social determinants of health.

Ms RIGHETTI (Switzerland) said that the Secretariat had a critical role to play working with governments to identify and reduce inequalities in health. Her delegation welcomed the initiatives mentioned in the report, especially research aimed at developing new tools for monitoring inequalities and identifying best practices, as well as training initiatives for health professionals, which should include an emphasis on social determinants of health and on adapting health services to combat inequalities. Weak health systems that were difficult to access were a significant determinant of health inequality, and ensuring access to the resources needed to lead a healthy life should therefore be part of the drive to achieve universal health coverage. Intersectoral action was essential in order to address social determinants, an approach that would be reinforced at the 8th Global Conference on Health Promotion. Switzerland noted with interest the joint United Nations initiative in Mozambique and Rwanda. It welcomed the growing recognition that health was a precondition for and an outcome and indicator of sustainable development. The work undertaken on the Millennium Development Goals had demonstrated that global health challenges could only be met through action on social, economic and environmental health determinants, and such determinants should certainly be reflected in the post-2015 development agenda.

Dr DAULAIRE (United States of America) said that his Government strongly supported a social determinants of health approach, which was a central aspect of its current health care reform initiative. WHO had an important role to play in working with Member States to identify best

practices, set targets and indicators that fit their political and social systems and establish standards for the collection and analysis of data on health disparities. The United States of America looked forward to reports on the collaboration between WHO and other organizations in the United Nations system on the selection, use and monitoring of a common set of indicators on social determinants of health. Since many of the indicators would pertain to matters falling outside the health sector, cross-sectoral collaboration would be critical.

Ms POLACH (Argentina) said that in order to achieve improvements in health it was crucial to adopt a comprehensive view of social, economic and environmental policies in order to foster intergovernmental and intersectoral action and generate synergy among public policies, recognizing that the health sector should take the lead in addressing social determinants of health, especially at the local level. Noting that Argentina had been a strong advocate of the inclusion of social determinants of health as a distinct category of work in the PAHO Strategic Plan for 2014–2019, she endorsed the views expressed by the delegate of Ecuador concerning the progress made on the issue in Latin America, incorporation of social determinants of health in the post-2015 development agenda and the involvement of agencies such as WTO and WIPO whose work had an impact on health.

Dr LOKADI OTETE OPETHA (Democratic Republic of the Congo) said that his country had updated its strategy on health system strengthening in 2010. The strategy called for intersectoral collaboration and partnerships for action on the various social determinants of health, as well as collaboration with civil society, the private sector and development partners. He emphasized the need to strengthen the legal framework for intersectoral collaboration and partnerships.

Mr OVIEDO (Costa Rica) said that it was imperative to integrate a health determinants approach into all health processes: a major challenge in achieving that end would be the incorporation of health in all policies. Other challenges in the post-2015 era would include increasing the production and quality of, and ensuring equitable access to, scientific knowledge and technologies for improving action on social determinants of health; strengthening human resources for health; and enhancing collaboration between institutions, sectors and civil society with a view to improving the health of populations and reducing health inequity.

Dr MARTÍNEZ DE CUELLAR (Paraguay) said that Paraguay's activities with regard to the social determinants of health had focused on reducing inequality and attaining health equity. To that end, public–public and public–private partnerships had been formed. Steps had been taken to address a number of health determinants, including access to drinking-water and sanitation and access to health care. An intersectoral technical commission had been set up to develop policies and strategies for the prevention and control of noncommunicable diseases. Steps had also been taken to increase the availability of online information and to strengthen epidemiological surveillance and establish a monitoring and evaluation mechanism in order to improve the quality of information.

Dr ALZAYANI (Bahrain), speaking on behalf of the Member States of the Eastern Mediterranean Region, welcomed WHO's initiatives to implement the provisions of the Rio Political Declaration and its collaboration with other partners. The Member States in the Region had endorsed a set of strategic directions, among other things for operationalizing the Rio Declaration, which stressed the need for disaggregated data and evidence on the key social determinants of health and on existing disparities within and between countries. Such data were crucial to understanding the barriers to improved planning, implementation and monitoring in some countries. In implementing the Declaration, consideration needed to be given to two key questions: what mechanisms were needed by Member States to improve multisectoral coordination and engagement, and how to utilize current resources effectively, while mobilizing others, in order to integrate a health determinants approach into programmes. WHO should ensure that global discussions, including on the post-2015

development goals, were complemented by discussions at the national and regional levels, in order to account for differing perspectives.

Professor ELIRA-DOKEKIAS (Congo) said that environmental determinants of health, especially deforestation and climate change, were particular concerns for his country and others in Africa. The many poverty-related health issues already faced by African countries were being exacerbated by the effects of climate change. His delegation would have liked to see the report focus more on the issue and called on the Secretariat to increase its action to mitigate the health risks caused by growing imbalances in ecosystems, changing weather patterns and natural disasters.

Ms CALDERÓN DE COPETE (Panama) said that Panama had made great progress in addressing social determinants of health, focusing in particular on the most vulnerable groups and, among other measures, extending social protection and free health care to women, children and the elderly. In her Government's experience, it was important to implement cross-cutting action that mainstreamed health determinants in all public health programmes, to foster awareness of health determinants in other sectors, and to utilize social networking to promote healthy lifestyles.

Ms Yu-Hsuan LIN (Chinese Taipei) said that social determinants of health must be addressed in order to reduce inequality and promote development. Regarding the core actions set out in the Rio Political Declaration, Chinese Taipei already offered universal health insurance with full coverage, but was still seeking to reduce health inequalities faced by those living in remote and rural areas where medical resources were in short supply. It was also working to improve maternal and child health services and preventive services and to address noncommunicable disease risk factors. In addition, it had taken an active role in facilitating regional exchange and cooperation aimed at reducing health inequalities and stood ready to provide financial, medical and human resources to assist countries in need.

Ms DELORME (The World Medical Association, Inc.), speaking at the invitation of the CHAIRMAN and also on behalf of the International Council of Nurses, the International Pharmaceutical Federation and the World Confederation for Physical Therapy, stressed the need for clear and complementary action on the social determinants of health and on the prevention of noncommunicable diseases. A coherent framework to address the social, economic and environmental determinants of health was essential to sustainable development, and health determinants should therefore be at the core of discussions on the post-2015 development goals. It was unfortunate that the report had not paid more attention to the key role that health professionals could play in addressing health inequalities. In that connection, education and training curricula for health professionals should incorporate a health determinants perspective, something that the Association would encourage.

Ms HAYNES (Medicus Mundi International – International Organisation for Cooperation in Health Care), speaking at the invitation of the CHAIRMAN, observed that the report included a list of activities without any qualitative assessment of their impact. Moreover, it reflected a rather narrow and superficial understanding of social determinants of health, and it failed to identify the root causes of health inequities. WHO should undertake more robust research and action to address the structural causes underlying many health determinants – for example, austerity measures introduced in response to the present financial crisis in Europe were leading to the privatization of health systems and the dismantling of the welfare state. Similarly, trade and financial liberalization policies and global power imbalances had a profound impact on health. WHO should also allocate more funding for its work on social determinants of health, as the amount allocated accounted for only 0.7% of WHO's overall programme budget. Such underfunding reflected a clear discrepancy between the Organization's stated commitment to action on social determinants of health and its actual work programme.

Dr KIENY (Assistant Director-General) said that, although WHO had been working with UNDP, ILO, UNICEF and other organizations, the Secretariat recognized the need to expand collaboration to other United Nations agencies and global development partners. She acknowledged the requests for support in capacity-building for the implementation of the Rio Political Declaration and noted that many Member States had already prioritized social determinants of health in their country cooperation strategies. Some had also established national commissions on social determinants of health. It was to be hoped that the financing dialogue and the Organization's new financing model would help to address the current lack of resources needed to scale up technical cooperation with Member States on the issue. The Secretariat recognized the need for a realistic and concise framework for monitoring progress on social determinants of health and was currently developing four sets of indicators for that purpose.

**The Committee noted the report.**

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

Dr ARMSTRONG (Secretary), noting that several Member States had requested further information on the novel coronavirus, suggested that before commencing its discussion of subitem 15.1, the Committee might wish to hear two presentations on the subject.

**It was so agreed.**

Dr FUKUDA (Assistant Director-General), using a slide presentation, drew attention to the unusual current global situation in which two exceptional new viruses – a novel coronavirus and avian influenza A(H7N9) virus – had emerged. The two were unrelated, but they were both highly pathogenic and considered to have the potential to evolve and spread. The first known cases of illness caused by the novel coronavirus – which a consensus group had recently agreed to call “Middle East respiratory syndrome coronavirus (MERS-CoV)” – had been detected retroactively in April 2012. To date, there had been 44 laboratory-confirmed cases and 22 deaths. Most cases had occurred in men in older age groups. It was not known how the index cases had become infected, but human-to-human transmission from index cases to contacts was known to have occurred. The virus had been acquired in-country from an unknown source in four countries: Jordan, Qatar, Saudi Arabia and United Arab Emirates. Cases associated with travel or contact with an infected traveller had also occurred in France, Germany, Tunisia and the United Kingdom of Great Britain and Northern Ireland. The vast majority of patients to date had presented with respiratory symptoms and many had developed severe pneumonia; immunocompromised individuals had sometimes exhibited atypical symptoms such as diarrhoea. No approved virus-specific vaccine or therapy had yet been identified, but general supportive care could be life-saving.

The Secretariat had assessed the situation as evolving, urgent and complex and was concerned about several critical gaps in understanding, the potential for sustained person-to-person transmission, and the lack of adequate preparation by countries and the global community for another severe pandemic so soon after pandemic (H1N1) 2009. The Secretariat's strategic goals with respect to both the novel coronavirus and avian influenza A(H7N9) virus were to protect people and communities, to assess and monitor the situation, to ensure preparedness by all countries and to provide global leadership and coordination. Proper application of the International Health Regulations (2005) would be crucial in order to minimize the public health and economic impact of the virus. Member States would need to ensure, in particular, that they upheld their obligations for notification and continued reporting. It was also essential to raise awareness at country level, especially among health workers and travellers, of the need to report any suspected cases.

Dr MEMISH (Saudi Arabia), outlining his country's response to novel coronavirus, said that 22 of the 44 laboratory-confirmed cases to date had been related to a cluster occurring in a health care facility in Saudi Arabia. The first reported case had occurred in June 2012 in a man aged 60 years. He had presented with pneumonia, had subsequently developed acute respiratory distress and renal failure and had died within less than a month. The patient's contacts had been investigated and none had been found to be symptomatic. It had not been discovered until late September 2012 that the illness had been caused by the novel coronavirus. In response to that discovery, the Ministry of Health had convened the National Scientific Committee for Contagious Diseases, coordinated with the WHO Regional Office for the Eastern Mediterranean and headquarters, and sought support from colleagues from the United States Centers for Disease Prevention and Control, Columbia University and EcoHealth Alliance.

The situation had been monitored closely in the subsequent months, especially at the time of the hajj, when several million pilgrims had travelled to Saudi Arabia. Strict surveillance had been carried out in the destination cities, including screening of any patient seen in hospital for respiratory symptoms in any of those cities. More than 3 million samples had been collected, all of which had tested negative. Samples collected from pilgrims when they departed Saudi Arabia after the hajj and/or when they re-entered their own countries had also all been negative.

A technical consultation meeting had been convened by the Regional Office for the Eastern Mediterranean in January 2013, during which sessions had been held on five topics: epidemiological information; virological and animal investigation; development of diagnostic tests; lessons learnt from severe acute respiratory syndrome; and risk communication and preparedness. A second expert consultation aimed at identifying the source of the virus had been held in March 2013. More than 500 samples from bats had been collected and none had tested positive for the virus.

In April and May 2013, there had been an outbreak of illness caused by novel coronavirus in the Al-Ahsa region of Saudi Arabia, with most reports coming from one private hospital. A Ministry of Health emergency team had been dispatched to the region, and WHO had been notified immediately after the first case had been confirmed in a laboratory on 24 April. Experts from the Regional Office for the Eastern Mediterranean and from several countries outside the Region had been consulted. The infection control measures put in place in the hospital had proved effective, and no new cases had been detected there since 1 May 2013. Contacts had been investigated extensively, and two cases had been identified. All cases had been reported to WHO in accordance with the International Health Regulations (2005). Active surveillance was ongoing across the country, and more than 1100 samples had been tested to date.

Many challenges remained, as the source of the virus had yet to be determined and many epidemiological aspects of the situation were still unclear. Diagnosis remained a challenge, as well, mainly because the virus had been patented by scientists who had not allowed it to be used for research by other scientists. The Government was working to strengthen laboratory capacity at the national level and would maintain active surveillance and continue to disseminate updated epidemiological information.

Professor MESBAH (Algeria) asked whether there had been any asymptomatic carriers of the virus.

Dr MEMISH (Saudi Arabia) said that it was not yet possible to tell whether community transmission was occurring because serological testing was not yet available.

Mr JAMIL (Iraq) asked if any joint epidemiological research had been undertaken by the countries affected by outbreaks and also asked for information on the availability of diagnostic test kits to enable countries such as his to ensure surveillance.

Dr FUKUDA (Assistant Director-General) said that the technical consultation had been convened by the Regional Office for the Eastern Mediterranean in January 2013 precisely for the

purpose of bringing together leading researchers and pooling the information available at the time. The Secretariat foresaw the need for additional meetings of that nature in order to stimulate as much collaboration and information exchange as possible.

Regarding the diagnostic kits, serological tests were still under development. The primary means of detecting the virus at present was polymerase chain reaction, for which the primers were publicly available and could be synthesized by national laboratories. In laboratories that did not have that capacity but could carry out the polymerase chain reaction testing, primers could be ordered.

Mr AL OWAIS (United Arab Emirates) asked whether, in order to respond to concerns of the public, the Secretariat could confirm that there was no need to restrict travel and no need to conduct screening at border points or to restrict trade as a result of the novel coronavirus outbreak.

Dr BROU (Côte d'Ivoire) asked what similarities there were between the novel coronavirus and the virus detected in China.

Dr ABDULLA (Maldives) enquired whether patenting of the virus had had any implications with respect to the cost of the primers needed for polymerase chain reaction testing.

Dr MEMISH (Saudi Arabia) said that the delay in development of a serological test and other diagnostic procedures was certainly related to patenting of the virus, which had been sent out of his country and patented; contracts had subsequently been signed with pharmaceutical companies, which now required anyone wishing to use the virus for research to sign a material transfer agreement. That should not have been allowed to happen.

Dr FUKUDA (Assistant Director-General) said that, for the moment, the Secretariat was not recommending any restrictions on travel or any screening for the virus at borders, which – even if it were considered advisable – would be difficult with the technology currently available. The Secretariat would continue to monitor the situation and inform Member States if any such restrictions or other actions became necessary.

As to the similarities between the two viruses, the most important ones were that both viruses were contained, but both also posed a risk of potential future spread. All countries needed to be aware of the risks and ensure that their surveillance systems were capable of detecting cases of illness possibly caused by either virus. Countries should also ensure that the procedures set out under the International Health Regulations (2005) were being followed, that their health care professionals were alert to the possibility of outbreaks and that good communication networks were in place so that the public could be kept informed.

Responding to the question about the cost implications of patenting of the virus, he pointed out that although the Pandemic Influenza Preparedness Framework applied strictly to pandemic influenza viruses, many of the concepts involved and the spirit behind it were relevant to the current situation and to the occurrence of any emerging infectious disease. In such cases, it was critical to avoid delays in the development of diagnostic tests and in the dissemination of information. He therefore strongly urged any country where infection had occurred to make the viruses available to laboratories, so that as much information about them could be obtained as quickly as possible and delays in producing and distributing diagnostic tests could be avoided. Such action should be undertaken systematically whenever any unusual pathogen was detected.

The DIRECTOR-GENERAL pointed out that any new disease came with uncertainties and that there were many questions about the novel coronavirus that could not yet be answered. Inability to answer certain questions, however, should not be equated with lack of transparency. The Secretariat was in the process of setting up joint expert groups on the novel coronavirus, as it had done on avian influenza A(H7N9) virus, and would share any information that became available with Member

States. She would welcome suggestions regarding epidemiologists and virologists with the requisite expertise who might form part of those groups.

WHO, a multilateral organization, provided a platform for Member States to collaborate and share information and knowledge and, more important, to share viruses and specimens. She urged national health authorities to make it clear to scientists in their countries that viruses and specimens should not be shared bilaterally in a manner that would result in their being subject to intellectual property restrictions; rather, they should be shared with WHO collaborating centres. Intellectual property matters must not stand in the way of governments' ability to protect their people's health. She would look carefully at the legal implications of the issue and would follow up with the Government of Saudi Arabia.

Underscoring again that intellectual property rights must not be allowed to stand in the way of public health actions, she pledged to mobilize the resources needed to ensure that critical public health work, such as that of Dr Fukuda and his team with respect to the novel coronavirus and the avian influenza A(H7N9) virus, would not be left unfunded.

(For continuation of the discussion, see the summary record of the eighth meeting, section 2.)

**The meeting rose at 17:05.**

## **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.**

## NINTH MEETING

Friday, 24 May 2013, at 14:35

**Chairman:** Dr W.T. GWENIGALE (Liberia)

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

**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) (continued)

Dr EL TAHER (Egypt) said that, ever since the outbreak of avian influenza A(H5N1), Egypt had devoted great attention to combating influenza, which had been monitored under the national disease surveillance system until the development of a specialized surveillance system for monitoring severe acute respiratory infections and influenza-like illnesses. Activities to prepare the entire health system and the public for dealing with potential epidemics had greatly contributed to the creation of health security in Egypt, which constantly reviewed and updated its influenza preparedness plans on the basis of new information provided by WHO. Full and effective implementation of the Pandemic Influenza Preparedness (PIP) Framework was vital, and support was essential for laboratory and disease surveillance systems. Technology for influenza vaccine manufacture must be transferred to as many countries as possible, and vaccines must also be fairly distributed among countries and individuals.

Dr KAMALIAH MOHAMAD NOH (Malaysia) endorsed the recommendations made by the Pandemic Influenza Preparedness Framework Advisory Group and recognized that strengthening the Global Influenza Surveillance and Response System (GISRS) through new or enhanced laboratory capacity at country level was essential for robust pandemic preparedness and response. She drew attention to the urgent need for WHO to conclude Standard Material Transfer Agreement 2s (SMTA 2s) with non-GISRS recipients of pandemic influenza preparedness biologicals and urged greater transparency in the Organization's discussions with vaccine, diagnostic and pharmaceutical manufacturers. She supported the Advisory Group's recommendation that WHO should establish a system for tracking the distribution and use of Partnership Contribution resources, in order to ensure equitable benefit-sharing with regard to the use of viruses, and that it should establish criteria for selecting countries eligible for Partnership Contribution funds.

Dr ABDULLA (Maldives) congratulated WHO and all those who had been involved in the swift response to the influenza A(H7N9) outbreak in China. The Government of Maldives was committed to maintaining an outbreak preparedness and response capability; however, the country lacked the capacity to produce influenza vaccines, diagnostics or pharmaceuticals and was heavily dependent on support from WHO and producing countries. Currently, the high cost of vaccines meant that immunization was restricted to meeting travel requirements, and timely availability of vaccines could not be guaranteed. Technical support would be needed in order to fulfil the country's plan to establish a national influenza centre and build capacity for influenza surveillance and response. Maldives also needed support in conducting disease burden studies, so as to extend provision of vaccines to high-risk groups, and in procuring and deploying vaccines in a timely manner. Regular training was also imperative for maintaining pandemic preparedness and response. She urged WHO to accelerate completion of the SMTA 2s.

Dr MELNIKOVA (Russian Federation) said that the outbreak of pandemic influenza (H1N1) 2009 and the recent cases of influenza A(H7N9) had confirmed the importance of the PIP Framework, and the Committee had the opportunity to decide on the measures that should be taken to improve it. In that regard, she supported the strengthening of laboratory capacity and epidemiological surveillance and the establishment of an H5N1 vaccine stockpile, as well as the measures taken to make rational use of the Partnership Contribution. Technical support should continue to be provided to developing countries, including vaccine production technology transfers. She welcomed the satisfactory progress in the negotiations with representatives of the pharmaceutical industry on the first SMTA 2s, which should lead to the establishment of transparent criteria governing their participation in the Partnership Contribution scheme. She urged all Member States to take note of WHO's work in reviewing the preparedness and response guidance in the light of the lessons learnt from the previous pandemic and in the preparation of practical guidance, for national influenza centres, on epidemiological surveillance and the effectiveness of antiviral agents. She commended China's cooperation in passing on information on the outbreak of influenza A(H7N9) and in delivering the virus to the State Research Centre for Virology and Biotechnology in the Russian Federation for research purposes.

Mr OVIEDO (Costa Rica) emphasized the importance of technology transfer among Member States as a means of sharing experience and resources. He suggested that the report should refer to the actions that had been taken in connection with the emergence of the influenza A(H7N9) virus. He would also welcome a further report on any agreements that had been reached with the industry, with particular emphasis on the status of structures for virus surveillance and information transfer mechanisms.

Dr ABDULRAHIM (Bahrain) said that there was a need to ensure that countries could have rapid access to vaccines and other materials, and also clearly to identify the biological materials that would be needed to combat the virus. The Secretariat must maintain its efforts to support developing countries and help to strengthen their capacity. It was also important to ensure technology transfer from the vaccine-manufacturing pharmaceutical companies, so that equitable access to vaccines could be guaranteed all around the world. She welcomed the progress made in implementation of the PIP Framework. There had been excellent cooperation on sharing of viruses, but countries also needed to exchange scientific knowledge that would contribute to the manufacture of vaccines.

Dr RUÍZ MATUS (Mexico) said that Mexico would be willing to share circulating strains or samples of other influenza virus subtypes with pandemic potential, once the necessary capacity to use the electronic virus traceability mechanism was in place. In return, Mexico sought equitable access to vaccines and antiviral agents for use in an influenza epidemic or pandemic. It was important for WHO to conclude negotiations on SMTA 2s with non-GISRS institutions.

Dr LEI Zhenglong (China) expressed appreciation of the important role played by the PIP Framework in the prevention and control of influenza and the outstanding efforts of WHO in facilitating the establishment of a transparent and equitable framework. The Chinese health authorities were playing an active role in coordinating the establishment of communication channels between vaccine manufacturers and WHO. They were also exploring the necessary steps for participation of Chinese manufacturers in the PIP Framework and providing support for the signing of SMTA 2s. After the outbreak of human cases of influenza A(H7N9) in April 2013, China for the first time had shared the isolated human strain of H7N9 with reference laboratories and WHO collaborating centres. The Chinese authorities would continue to support global influenza surveillance activities, share viruses and related benefits and contribute to international vaccine reserves. It was rigorous in controlling outbreaks within the country. He urged WHO to find out about the overall situation of global vaccine manufacturers, in order to formulate more detailed and operable rules for the implementation of the Framework.

Mr KLEIMAN (Brazil) said that the approach outlined by the Advisory Group would ensure transparency, the sharing of information and samples, and access to benefits. He encouraged the Secretariat to explore with Member States the possibilities of using the principles of the PIP Framework to tackle other public health emergencies, such as the emergence of the novel coronavirus. He recognized the importance of the signing of the first SMTA 2 and the need for further agreements. He also acknowledged the payment of the Partnership Contribution by a section of the vaccine industry, highlighting the need to identify the beneficiaries of such contributions in a transparent manner and to determine the proportions of funds to be provided by each contributor, so that the process could be completed in 2013. Implementation of the Framework would contribute to the formulation of principles for WHO's engagement with the private sector and nongovernmental organizations in the context of WHO reform.

Dr TRIONO SOENDORO (Indonesia) requested the Secretariat to expedite the formulation of technical guidance in full compliance with the terms of reference of GISRS. Indonesia had worked with a WHO collaborating centre on the implementation of a Standard Material Transfer Agreement 1 (SMTA 1), which had resulted in the characterization of the Indonesian virus as one of the candidate influenza vaccines. He welcomed the signing of the first SMTA 2 in December 2012 with one of the three largest manufacturers of influenza vaccines and looked forward to the conclusion of similar agreements. In that connection, he requested that the benefit-sharing mechanism should be established in a timely manner and Member States informed of the procedures.

Mr THOMSON (Switzerland) welcomed the progress made on the SMTA 2 and strongly supported implementation of the PIP Framework, which would serve not only to increase global health security but also to foster international solidarity during pandemics, as well as increase equitable access to vaccines. It also illustrated the growing role of public/private sector partnerships in resolving health problems.

Dr Jen-Hsiang CHUANG (Chinese Taipei) described the steps being taken in the areas of vaccine production and immunization programmes. On 24 April 2013, Chinese Taipei had confirmed the first human case of influenza A(H7N9); the health authorities continued to exercise all precautions in order to control avian-to-human transmission. He appreciated the action of the WHO collaborating centre in Beijing for sharing the H7N9 virus.

Dr FUKUDA (Assistant Director-General) said that the comments of delegates attested to the importance attached to the PIP Framework and the need to accelerate its implementation. A number of delegates had called for transparency in terms of benefit provision and related activities.

In reply to the delegate of the United States of America, he affirmed that every effort would be made to bring about cooperative working in areas of potential overlap between the PIP Framework and other frameworks, in particular, the Global Action Plan for Influenza Vaccines and the International Health Regulations (2005). He clarified that the funding for capacity-building to which WHO had access through the PIP Framework was the Partnership Contribution, the largest percentage of which, namely 70%, was for laboratory capacity and surveillance. The Partnership Contribution would be subject to scrutiny by Member States, civil society and the pharmaceutical companies that had contributed, in order to ensure transparency in how the funds were distributed, as well as outputs and deliverables. WHO would examine the process for transparency, and the results of its work would be presented in a report. Turning to the comments made by the delegate of Paraguay, he drew attention to the shipping fund that allowed countries to send specimens to a WHO collaborating centre free of charge. WHO also provided specific training in the packaging of specimens.

In reply to the delegate of Australia, he clarified that two SMTA 2s had been completed and five other negotiating processes were in progress. Replying to the delegate of Japan, he said that following the influenza A(H1N1) 2009 pandemic, work had begun on revising the guidance on pandemic preparedness, including pandemic phases and severity scale, with input from the Review Committee

on the Functioning of the International Health Regulations (2005), as well as national experts. He hoped that the interim guidance would soon be available and requested feedback from Member States for inclusion in the final version of the guidance.

He had noted that some delegates had expressed their very helpful agreement with the recommendation of the Pandemic Influenza Preparedness Framework Advisory Group that up to 10% of the funds over a four-year period could be used to support the Secretariat.

He assured the delegate of Maldives that WHO would provide support for the development of a national influenza centre, as it had with a number of other countries. Replying to the delegate of Indonesia regarding benefit-sharing and the nature of the agreements being made with the commercial entities, he noted that one company had agreed to donate 7.5% of its vaccine production in real time to WHO in the event of a pandemic; to provide an additional 2.5% of its production at affordable prices; to donate 2 million doses of antiviral medicines to WHO; and to make 8 million courses available to WHO at affordable prices.

### **The Committee noted the report.**

**Poliomyelitis: intensification of the global eradication initiative:** Item 15.3 of the Agenda (Document A66/18)

Ms LANTERI (Monaco), speaking on behalf of the Member States of the European Region, commended the report for accurately reflecting the comments made at the previous session of the Executive Board. Noting the ambitious nature of the polio eradication and endgame strategic plan 2013–2018, she called for it to be independently reviewed each year and for information to be supplied on how that would be carried out.

She firmly condemned the violence perpetrated against health workers, which deprived children of vaccination and could compromise earlier achievements. Expressing profound sympathy to the families of those workers, she called on the Member States concerned to ensure a safe environment as a matter of urgency, so that optimal immunization coverage could be achieved. With regard to legacy planning, she strongly supported the three main goals, in particular the integration of poliomyelitis-related work into existing public health programmes. However, financing the programme remained a concern: unless the necessary human and financial resources were made available, earlier achievements might be compromised. In that regard, she welcomed the commitments made at the Global Vaccine Summit (held in Abu Dhabi, United Arab Emirates on 24 and 25 April 2013), amounting to US\$ 4000 million of the US\$ 5500 million needed.

Dr MUHAMMAD (Nigeria) expressed appreciation for the global solidarity shown during and after the killing of the health workers. Security remained a concern, but the Government of Nigeria was determined not to allow the incident to derail the vaccination programme. He expressed his condolences to the families of health workers elsewhere who had also lost their lives.

Nigeria continued to make progress in eradicating poliomyelitis as a result of political commitment, the establishment of national and state emergency centres, improved financial resources and additional funding pledged during the Global Vaccine Summit. There had been a 67% reduction in the number of wild poliovirus cases in Nigeria compared to 2012, and a reduction in the number of children missed during each vaccination round testified to an improvement in the quality of the campaigns. Special scaling-up strategies were being implemented, especially in the north-east of the country; they included the use of teams to carry out vaccination at international borders, airports and other locations frequented by transient populations; supplementary immunization activities synchronized with neighbouring countries; and intensification of routine immunization and acute flaccid paralysis surveillance in poliomyelitis-free States, in preparation for the endgame.

Dr MASHAL (Afghanistan) described some of the efforts being carried out in Afghanistan to complete poliovirus eradication. So far in 2013, only two cases of poliomyelitis had been confirmed

and no poliovirus had been identified in the south of the country, which had been a key reservoir. Nevertheless, access to children in unsafe areas was difficult, and a new epidemiological situation had arisen in the east of the country. He commended the polio eradication endgame strategic plan 2013–2018, in particular the emphasis it placed on routine immunization. Ensuring the availability of affordable inactivated poliovirus vaccine would help in extending coverage among target populations.

Dr NISHTAR (Pakistan) said that there had been a more than 65% reduction in cases of poliomyelitis in Pakistan between 2011 and 2012. Thus far in 2013, there had been 50% fewer cases than in the corresponding period in 2012. Those advances had taken place despite disruption caused by natural disasters and insecurity, which had resulted in the killing of Pakistani health workers by terrorists. To build on the achievements to date, a number of measures had been taken, including establishing a monitoring system and vaccination points in locations extensively used by people in transit, ensuring that children were vaccinated inside all international airport departure lounges, and putting border coordination mechanisms in place for synchronized immunization activities. The Government had drawn up a national emergency action plan following a broad consultative process. It had also created channels of accountability, in order to secure performance and delivery, and routine immunization would be further strengthened. The media would be fully involved in efforts to counter negative propaganda, and civil society would be mobilized in an attempt to overcome parental opposition to vaccination. She paid tribute to the bravery of the health workers who continued to carry out their work despite the danger, adding that the Government was working with law enforcement agencies to ensure security for the large numbers of health workers involved in immunization days. Efforts were also being made to engage the support of religious scholars so that the importance of poliomyelitis eradication and the right of children to health care was made known at grass roots level.

Dr AL-TAAE (Iraq), speaking on behalf of the Member States of the Eastern Mediterranean Region, expressed support for the polio eradication and endgame strategic plan 2013–2018 and highlighted the importance of tracing other potential areas at risk of an outbreak, following the recent discovery of a case in Somalia. Iraq was participating in international efforts to combat any obstacles to poliomyelitis eradication and was working to increase routine immunization and surveillance of acute flaccid paralysis. Noting that further efforts were being carried out with Afghanistan, Iran, Pakistan and WHO to enhance all poliomyelitis eradication activities, he called on stakeholders to continue to support such initiatives, in particular in countries with re-established transmission.

Professor BAGGOLEY (Australia) commended the progress made so far against poliomyelitis and expressed support for intensification of efforts to reach the eradication goal. He also commended the emergency actions being taken by the Governments of Afghanistan, Nigeria and Pakistan to avert risks to health workers, as well as the efforts of international partners, particularly UNICEF, to reach the least accessible children and to train health workers in service delivery.

Ms REITENBACH (Germany) said that at the Global Vaccine Summit Germany had contributed a significant amount towards the more than US\$ 4000 million that had been pledged in support of the Global Polio Eradication Initiative. However, it still remained to interrupt transmission in poliomyelitis-affected countries before the end of 2014 and to maintain the gains made thus far. Serious consideration should be given to vaccinating all travellers from poliomyelitis-affected countries. In order to ensure the sustainability of the Initiative, the medium-term goal should be to move from poliomyelitis vaccination campaigns to routine immunization.

She expressed support for WHO's efforts, following the tragic incidents in December 2012 and February 2013, to reinforce the safety of health workers and said that Germany would pledge an additional €5 million over and above the €100 million already committed, to be used for relevant measures.



MR ÁLVAREZ LUCAS (Mexico) said that his country agreed that the eradication of poliomyelitis was a worldwide health priority. For as long as the disease existed anywhere in the world, for as long as there was a risk of imported cases, it was necessary to maintain and even step up immunization.

Dr USHIO (Japan), commending both the Global Polio Emergency Action Plan 2012–2013 and the polio eradication and endgame strategic plan 2013–2018, said that effective implementation would be needed and progress should be regularly monitored and evaluated by an independent evaluation committee. With regard to the transition to bivalent oral poliovirus vaccine and the introduction of inactivated poliovirus vaccine, adequate steps, including risk assessment, must be taken to avoid confusion in countries where trivalent oral poliovirus vaccine was currently in use. He hoped that the discussions on legacy planning would be widely applied to other areas of public health.

Dr MELNIKOVA (Russian Federation) emphasized that implementation of the Global Polio Emergency Action Plan 2012–2013 in support of national emergency plans in poliomyelitis-affected countries had shown the effectiveness of such joint efforts. She expressed support for the polio eradication and endgame strategic plan 2013–2018 and drew attention to the legacy element, which required the transfer of relevant capacities, processes and assets. The Russian Federation was making a specific contribution to the Global Polio Eradication Initiative by providing support to countries of the Commonwealth of Independent States.

Professor ARSLAN (Bangladesh) noted that considerable progress had been made in eradicating poliomyelitis in the South-East Asia Region. The last case linked to wild poliovirus had been reported in January 2011 and the Region was on track to achieve poliomyelitis-free certification in February 2014. A total of 30 countries remained at high risk of importation of poliovirus and would need to carry out supplementary immunization activities, in order to make the concerted global achievement permanent. Although Bangladesh had been free of poliomyelitis since 2006, it continued to hold national immunization days. The withdrawal of type 2 oral poliovirus vaccine and its replacement with inactivated poliovirus vaccine would necessitate having an adequate global supply of the latter. He therefore appreciated the initiative to make the latter available at an affordable price. Bangladesh had experience in maintaining its poliomyelitis-free status through its skilled workforce, which it would be willing to share with other Member States in order to keep the world free of poliomyelitis.

Dr YILMAZ (Turkey) said that poliomyelitis eradication should be high on the public health agenda: the longer the goal of eradication was delayed, the more difficult it would be to reach. High-level political commitment would be essential. The new polio eradication and endgame strategic plan 2013–2018 would reinforce the Global Polio Eradication Initiative, and countries in which poliomyelitis remained endemic should focus on the issues raised in it. Commitment to preparing and implementing national emergency plans would be the key to future success.

Dr DARIN AREECHOKCHAI (Thailand) said that having reviewed the strategic plan, she recognized that a number of major steps would have to be taken during the coming six years. In particular, countries using trivalent oral poliovirus vaccine would need to have bivalent oral poliovirus vaccine licensed by the national drug regulatory authority, and the availability and affordability of inactivated poliovirus would have to be guaranteed. She called on the Secretariat to support Member States in the effective and timely implementation of the six-year strategic plan, particularly in connection with the poliovirus vaccine transition phases.

Dr DAULAIRE (United States of America) praised the report on poliomyelitis eradication as a critical measure of WHO's ability to contribute to global health. The recent reduction in the number of cases of poliomyelitis was encouraging. Noting that the polio eradication and endgame strategic plan 2013–2018 had been strongly endorsed during the Global Vaccine Summit, and that an impressive level of financial support had been pledged, he said that his President had proposed to donate US\$ 165 million to poliomyelitis eradication in 2014.

The recent discovery of imported poliomyelitis cases in Somalia and northern Kenya reinforced the urgency of containing and eradicating poliomyelitis. While he acknowledged the problems caused by the violence against health workers, it was crucial to improve the management of immunization programmes, as highlighted in the recommendations of the Independent Monitoring Board. The Executive Board at its 132nd session had reached consensus on the Independent Monitoring Board's recommendation to promote the vaccination of travellers to and from remaining poliomyelitis-affected countries. He congratulated Pakistan on the leadership shown in ensuring that travellers provided proof of vaccination and vaccinating children on departure from Pakistan. He also welcomed Nigeria's action in setting up vaccination posts along its land borders and its intention to do the same at international airports.

He called on WHO to ensure that countries implemented immediately and fully the existing WHO recommendations on vaccination of travellers; to urge countries to reach agreement with their neighbours on denying transit to travellers who refused vaccination at border crossings; and to consider additional measures as needed to ensure that wild poliovirus transmission was halted by December 2014.

He supported the call by the Independent Monitoring Board for the Review Committee on the Functioning of the International Health Regulations (2005) to raise the question of vaccinating travellers, and to consider issuing a standing recommendation from the beginning of 2015 in the event of any ongoing transmission of poliomyelitis after the end-2014 target date.

Dr LANE (United Kingdom of Great Britain and Northern Ireland) said that his country remained deeply committed to the goal of poliomyelitis eradication and had pledged £300 million at the Global Vaccine Summit. The new endgame strategy was ambitious and would require rigorous, transparent monitoring and the provision of evidence of progress against milestones, with course corrections as new evidence became available. Member States would want their investments to go beyond poliomyelitis eradication campaigns and be used to strengthen routine immunization and the health services that hardest-to-reach populations most needed. He welcomed the determination and commitment shown by the remaining poliomyelitis-affected countries.

Dr LEI Zhenglong (China) congratulated WHO on its efforts to eradicate poliomyelitis, as well as the Governments of Afghanistan, Nigeria and Pakistan on their progress towards that goal. In pursuit of the efforts to achieve global eradication, he made the following suggestions: coordination of all available resources in order to provide technical and financial support for interrupting transmission in poliomyelitis-affected countries; strengthening of surveillance and risk assessment services in those countries; and creation of conditions conducive to, and reinforcing of, cooperative vaccination efforts across national borders.

Dr SADRIZADEH (Islamic Republic of Iran) commended the polio eradication and endgame strategic plan 2013–2018. The four major objectives and associated milestones were realistic and achievable by the defined target date, provided that the availability of inactivated poliovirus vaccine was enhanced and the transfer of new production technology for it guaranteed. Attaining the goals of the strategic plan would require sustained political commitment at all levels, accountability, and adequate funding throughout its duration. Strengthening cooperation between poliomyelitis-affected countries and their neighbours, and generous financial support from donor countries, would be important factors in eradicating the disease. Such partnerships were being rigorously developed in a

subregional initiative, in which the Regional Office for the Eastern Mediterranean was playing a catalytic role.

Dr EL TAHER (Egypt) said that survival of the virus in any part of the world meant that no one was safe, as demonstrated by Egypt's detection, through its environmental surveillance system, of wild poliovirus from Pakistan in sewage samples taken from two areas of Cairo in December 2012. A vaccination programme had been introduced, reaching 100% coverage, and as a result no cases had occurred in children. While the final phase of the new strategic plan entailed the withdrawal of the type 2 component of oral poliovirus vaccine and the introduction of a dose of inactivated poliovirus vaccine, some countries might not be in a position to take on the high costs that would be associated with the Expanded Programme on Immunization during that phase. WHO must also support developing countries in acquiring vaccines at affordable prices.

Mr PLAVČAN (Slovakia) said that his country continued to carry out immunization and other activities to maintain its polio-free status in accordance with the approach of the Regional Office for Europe. Recognizing the importance of maintaining eradication activities at the global level, Slovakia was providing financial support to the Global Polio Eradication Initiative for 2013 to help provide vaccines for Afghanistan.

Dr TRIONO SOENDORO (Indonesia) acknowledged the need for a comprehensive endgame strategy and a strong post-eradication strategy. Switching from trivalent to bivalent oral polio vaccines would present programmatic and financial challenges, particularly when the shift would include the introduction of inactivated polio vaccine, with its sophisticated and costly production technology. Indonesia was in the process of analysing the situation, taking into account the country's current epidemiological scenario, clinical and financial aspects and production capability. He requested the Secretariat and other relevant stakeholders to provide support to Member States, to encourage manufacturers to provide sufficient quantities of vaccines at affordable prices, including inactivated poliovirus vaccine, and to facilitate access for developing countries to production technologies.

Dr ABDULRAHIM (Bahrain), welcoming the efforts made by WHO to intensify the eradication campaign, said that despite the problem of propagation of the virus in the three countries where poliomyelitis was still endemic, significant progress had been made towards eradicating poliomyelitis through the implementation of WHO global strategies. Global eradication would require commitment at all levels, together with an assessment of capacities and of needed improvements. She urged the Secretariat and its partners to continue their consultations with pharmaceutical companies in order to improve capacities and address the cost of vaccines and immunization campaigns.

Professor PRASAD (India), acknowledging that the polio eradication and endgame strategic plan 2013–2018 had to be carefully executed to manage the risks associated with its implementation, said that his country would hold consultations with relevant experts at the national level in order to identify the technical and financial implications. India was supporting global eradication efforts by sending technical and medical officers to provide support in interrupting transmission in Afghanistan, Nigeria and Pakistan and was committed to strengthening routine immunization. There had been no case of poliomyelitis in India since 2011, and the Government was coordinating with state governments to provide information to the Global Commission for the Certification of the Eradication of Poliomyelitis; it was hoped that the South-East Asia Region would be certified as polio-free in early 2014. Legacy planning activities were also being undertaken, including measures to improve vaccination coverage.

Dr WAMAE (Kenya) said that as long as the wild poliovirus was still in circulation, no country was completely safe. Routine coverage with oral poliovirus vaccine stood at 85% in her country; however, in May 2013 there had been a confirmed report of wild poliovirus in a neighbouring country

and shortly afterwards, two persons in the Daadab refugee camp who had come into contact with a young girl with acute flaccid paralysis had tested positive for type 1 wild poliovirus. Kenya had accordingly activated its polio outbreak preparedness and response plan and raised the vaccination target age to 15 years; it would shortly be initiating a number of vaccination campaigns, including a cross-border campaign. The Ministry of Health was also working with partners, including WHO, to respond to the outbreak; further support was needed in that regard. In addition, as countries began to change from using oral poliovirus vaccine to inactivated poliovirus vaccine, there was a need to look at the challenges involved, particularly with regard to cost and logistics.

Dr ABDULLA (Maldives) said that her country, together with other countries in the South-East Asia Region, was strengthening its surveillance and response strategy against a possible reintroduction of poliovirus in the country. Some difficulties remained with regard to surveillance and vaccination refusal, particularly as a result of misinformation spread by the anti-vaccination lobby. Maintaining polio-free status required continued preparedness, through surveillance and rapid response, as well as high immunization coverage. Improved cross-border collaboration was also important.

Ms GOLBERG (Canada) said that significant progress had been made since the declaration of poliomyelitis as a global health emergency at the Sixty-fifth World Health Assembly, and the recent Global Vaccine Summit had successfully galvanized a significant proportion of the financial resources needed for a final push towards eradication. She urged all donors who had pledged funds to turn them into contributions, programmes and activities. However, major challenges still existed, including security and the fostering of local acceptance of vaccination. She commended the commitment of the three remaining countries endemic for the disease and the courage of their local health workers. It was vital that governments and religious and community leaders promote science-based information and ensure safe access for health workers; the efforts made by the Regional Office for the Eastern Mediterranean to engage Islamic scholars and leaders should be particularly noted. In addition, it was crucial that the polio eradication and endgame strategic plan 2013–2018 be closely aligned with the goals of the Global Vaccine Action Plan 2011–2020.

Dr GOERENS (Luxembourg) said that the recent cases reported in Kenya and Somalia made it necessary to multiply global efforts to eradicate poliomyelitis. He paid tribute to Afghanistan, Nigeria and Pakistan for their efforts but acknowledged that new challenges were appearing, particularly with regard to security; increased protection for immunization campaigns was vital, and national and regional security cooperation mechanisms should be strengthened in that regard. He welcomed the success of the Global Vaccine Summit; failing to protect future generations because of a budget deficit would be unacceptable. Luxembourg would continue to contribute funding beyond 2013, to enable attainment of the goals of the polio eradication and endgame strategic plan 2013–2018.

Dr FIKRI (United Arab Emirates) said that his country was committed to fulfilling its commitments to WHO and other partners and favoured intensification of current efforts to eradicate poliomyelitis. He welcomed the comments made regarding the Global Vaccine Summit and thanked all Member States that had participated.

Ms VALLINI (Brazil) said that her country's experience had shown that eradication of poliomyelitis could be achieved through a combination of strong epidemiological surveillance and decentralized immunization activities throughout the country. With health authorities playing a leading role, it was also important for communities, families and civil society to participate actively in national vaccination campaigns. Cessation of oral poliovirus vaccine use after certification of global eradication should continue to be the objective of an inclusive debate with the participation of all stakeholders.

Dr Yi-Chun LO (Chinese Taipei) said that strong political commitment was essential in the fight to eradicate poliomyelitis and minimize the risks of reintroduction and re-emergence. A standardized immunization record system introduced in 1983 to monitor the immunization status of each child had contributed to eradication of poliomyelitis from Chinese Taipei. Chinese Taipei welcomed the new strategy endorsed by the Strategic Advisory Group of Experts on immunization regarding the introduction of inactivated polio vaccine in place of the traditional oral poliovirus vaccine and would continue to collaborate with all countries in order to achieve a polio-free world.

Ms DIETTERICH (International Federation of Red Cross and Red Crescent Societies), speaking at the invitation of the CHAIRMAN, paid tribute to the health workers from the Afghanistan Red Crescent Society mobile health team who had lost their lives in recent months. Although tragic, such incidents only served to strengthen her organization's resolve to ensure that every child and every adult had access to an essential package of health services, including immunization. The national societies of her organization served as vital health auxiliaries to the governments of affected countries, from which the members and volunteers usually came. Civil society organizations delivered as much as 60% of health services in some developing countries and required the support and resources to do so.

Mr STENHAMMAR (Rotary International), speaking at the invitation of the CHAIRMAN, said that the progress made since eradication of poliomyelitis had been declared a programmatic emergency had been remarkable, in part as a result of the introduction of new strategies including mapping using global positioning system technology and the expansion of outreach to migrant and nomadic populations. Nevertheless, accountability, management and supervision of vaccination campaigns in the three countries endemic for the disease needed to be strengthened still further to stop transmission of wild poliovirus. The recent outbreak in Somalia highlighted the significant risk to children in all countries until poliomyelitis was eradicated. Welcoming the significant commitments made at the Global Vaccine Summit, he urged implementing entities to use the funds judiciously, in order to take advantage of the global investment in the eradication of poliomyelitis. Member States should maximize their political and financial support to provide the remaining US\$ 1500 million needed to achieve the objectives outlined in the strategic plan. Rotary International had committed more than US\$ 1000 million to polio eradication over the years and stood ready to help further.

The CHAIRMAN, acknowledging the many statements of concern, expressed sympathy on behalf of all the members of the Committee for the deaths of poliomyelitis workers at the hands of terrorists in Nigeria and Pakistan. He extended the Committee's condolences to their families, and its support to the Governments of the two countries for their efforts to improve security for such workers.

Dr AYLWARD (Assistant Director-General) said that the eradication efforts were on an emergency footing; more than 2500 new personnel had been recruited and deployed to the most difficult areas in the remaining countries to help governments implement their emergency plans. Those efforts had resulted in real progress; for the first time in history, six months had passed without the detection of type 3 virus anywhere in the world. Key reservoirs of the virus in southern Afghanistan and Pakistan had also been quiescent for the same period. The Global Vaccine Summit had seen the finalization of the endgame plan, and he thanked Member States for their contributions to and endorsement of the plan. He also thanked all who had made financial pledges, expressing appreciation to the Government of the United Arab Emirates for hosting the Summit and encouraging Member States to translate the pledges into funding as soon as possible. However, despite the generous pledges made, there was still a funding shortfall of US\$ 1500 million.

There were still several concerns, particularly with regard to the security of health workers; attacks continued to happen in some countries and additional measures were being taken at country and regional levels to restructure operations and help build a safe environment. In addition, although cases of poliomyelitis were at their lowest number in history, the virus was still being found, namely

in Cairo at the end of 2012 and recently in northern Kenya and Somalia. As the virus was continuing to move, one element of the polio eradication and endgame strategic plan 2013–2018 was to address reservoirs. In addition, the plan included activities to boost global immunity as much as possible through the introduction of inactivated poliovirus vaccine. That would be a huge task as 127 countries were still only using oral poliovirus vaccine. WHO was working hard to develop supply and financing strategies to ensure rapid implementation, starting with the highest-risk countries.

Responding to the questions and comments by Member States, he explained that the Global Polio Eradication Initiative was committed to using its substantial assets on the ground to work with the GAVI Alliance in boosting routine immunization; the polio eradication and endgame strategic plan contained several firm commitments and concrete actions in that regard, in line with the Global Vaccine Action Plan. With regard to the need for rigorous monitoring, he explained that the Independent Monitoring Board had agreed, at the request of the Director-General, to extend its mandate to the end of 2015; moreover the Strategic Advisory Group of Experts on immunization had agreed to oversee the second objective of the plan on a biannual basis, and the Global Commission for the Certification of the Eradication of Poliomyelitis would be responsible for the third objective. WHO was already starting the process of legacy planning through regional committee meetings; the plan was then to engage with a broader range of stakeholders and present a report to the Sixty-seventh World Health Assembly. He acknowledged that there had been shortages of bivalent and trivalent vaccines during 2012 as a result of the exit of two key manufacturers from the oral poliovirus vaccine market. However, thanks to the efforts of UNICEF and other partners, more manufacturers had been brought on line and it was hoped that by October 2013, supply would meet demand. He thanked the Member States for their patience during the vaccine shortage and for amending their immunization plans to ensure that the vaccines went where they were most needed. The Director-General was considering convening a meeting of the Review Committee of the International Health Regulations (2005) to study the potential role of a standing recommendation on the vaccination of travellers from 2015 if needed. With regard to ensuring the availability and affordability of inactivated poliovirus vaccine, he said that there were currently sufficient stocks of the vaccine to implement the endgame plan and that there had been a 65% reduction in price over the previous 12 months. In addition, WHO had been working on technology transfer to six vaccine manufacturers in developing countries and was looking to develop additional capacity for more manufacturers during 2013. At the same time, a global vaccine supply and financing strategy for inactivated poliovirus vaccine was being developed to ensure that vaccination continued to move forward. He expressed appreciation for the support, solidarity and condolences expressed by Member States and thanked those countries that had announced additional funding to help ensure that vaccination activities were as safe as possible as efforts continued.

**The Committee noted the report.**

**2. COMMUNICABLE DISEASES: Item 16 of the Agenda**

**Global vaccine action plan: Item 16.1 of the Agenda (Document A66/19)**

Dr DAHL REGIS (Bahamas) welcomed the leading role being played by WHO in the coordination of partner agencies with regard to activities under the global vaccine action plan and the integration of the recommendations of the Strategic Advisory Group of Experts on immunization into the work of the Secretariat. Maintaining measles elimination was a particular challenge for the Region of the Americas, and she was concerned that the targets contained in the global vaccine action plan would not be sufficient to address importation of the disease into regions that had already eliminated it. More efforts were needed to encourage privileged sectors of society to value immunization and to support the vaccination of hard-to-reach and vulnerable populations.

**Dr Ross took the Chair.**

Dr AL-TAAE (Iraq) said that through the Expanded Programme on Immunization, rotavirus and *Haemophilus influenzae* type b vaccines had been introduced in his country, and it was hoped to introduce conjugated pneumococcal and human papillomavirus vaccines in future. Introduction of new vaccines should be based on evidence and community needs and be consistent with epidemiological and demographic variables. Introduction of inactivated poliovirus vaccine would present many challenges, and support was needed from WHO and other organizations in areas such as capacity-building for health personnel and institutions. Vaccination of high-risk groups and mass gatherings also needed to be addressed. WHO should work to enhance integrated activities between countries and regions. Advocacy, communication and social mobilization were important tools that should be strengthened and implemented as part of a primary health care approach.

Dr ALHAJERI (Bahrain), welcoming the efforts to establish a global plan and mechanisms for the inclusion of all social groups in the Expanded Programme on Immunization, said that Bahrain, as part of its ongoing support for that Programme, had participated in the activities marking Vaccination Week ever since it had first been launched by the Regional Office for the Eastern Mediterranean. WHO must support Member States in drawing up their national plans in line with the global vaccine action plan and strengthen their implementation capacities. Guidelines should also be provided for alignment of the monitoring, evaluation and accountability processes at national level with those at regional and global levels. Bahrain endorsed the proposed framework for those processes.

Mrs CARTER TAYLOR (Barbados) said that her country was seeking to address vaccine-preventable diseases through interventions including measures aimed at achieving high routine immunization coverage, surveillance activities and the introduction of new vaccines where applicable. The Secretariat should continue to work with Member States over the Decade of Vaccines in order to implement the global vaccine action plan. Barbados was honoured to have been selected to serve on the Strategic Advisory Group of Experts on immunization to monitor the progress on the action plan.

Dr DOGBE (Togo), speaking on behalf of the Member States of the African Region, said that despite numerous difficulties, those countries had made significant progress in vaccination coverage; however, countries affected by conflict were facing a number of challenges in that regard. He welcomed the support of the GAVI Alliance and the international community for the introduction of new vaccines in the African Region. However, given the situation of countries in the Region, it should be adequately represented in the Strategic Advisory Group of Experts on immunization. Although the African Region greatly appreciated the initiative to monitor the commitment of various partners with regard to immunization, such monitoring should be part of the Accountability Framework for the United Nations Secretary-General's Global Strategy for Women's and Children's Health and the Global Fund to Fight AIDS, Tuberculosis and Malaria. National bodies should document best practices and develop recommendations on how to improve immunization services. At the country level, work should concentrate on strengthening targeted communication strategies, intensifying community and government commitment, advocating for lowered vaccine costs, and promoting research on vaccines and immunization, including against those illnesses that contributed to the burden of noncommunicable disease.

Dr ATTAYA LIMWATTANAYINGYONG (Thailand) said that the introduction of new vaccines required an evidence-based decision mechanism and depended on epidemiology, efficacy, cost-effectiveness, budgetary impact, cold chain capacity and health systems' scale-up capacity. In the action plan's proposed indicator on the introduction of new or underutilized vaccines, the phrase "based on adequate evidence and the context of the country" should be inserted after "new or underutilized vaccines". The insertion would provide flexibility to countries that were not eligible for GAVI Alliance support, enabling them to make the best decision based on their national situation. A

new indicator should also be added to the final strategic objective and should read “Progress towards institutional capacity to generate evidence to inform the introduction of new and underutilized vaccines”. In addition, the indicator for the first strategic objective, “Domestic expenditures per person targeted”, should be replaced by the existing indicator used by WHO and UNICEF, namely “Percentage of routine EPI vaccines financed by government”, which provided a better representation of the financial investment by a country in immunization activities. In order to achieve strategic objectives 3 and 5, global expansion of vaccine production capacities was key; therefore an additional strategic objective-level indicator was required, reading “Number of WHO prequalified vaccine manufacturers in developing countries”.

Dr ABANIDA (Nigeria) said that the cost of the basic package to vaccinate a child had risen rapidly and that there was minimal global information to enable tracking of vaccine prices. Monitoring vaccine prices and setting global norms for the cost of vaccines were important tools that would enable countries to accurately plan and prepare funding for immunization programmes, especially for countries that were ceasing to be eligible for GAVI Alliance support. He urged WHO to continue its work to develop indicators to track vaccine prices as part of the action plan’s monitoring, evaluation and accountability framework.

Dr DA COSTA SARMENTO (Timor-Leste) said that the global vaccine action plan provided a strategic framework to guide vaccination priorities during the Decade of Vaccines 2011–2020 and for the annual World Immunization Week. She expressed appreciation to the Regional Director for South-East Asia for declaring 2013 to be the Year of Intensification of Routine Immunization in the Region, as that had enabled Timor-Leste to identify critical areas for action. In collaboration with WHO, the GAVI Alliance and other relevant partners, Timor-Leste had been able to introduce a pentavalent vaccine in 2012. Developing countries, in particular, should have the opportunity to introduce vaccinations for other vaccine-preventable diseases, such as pneumococcus and rotavirus infections, at low prices.

Dr MELNIKOVA (Russian Federation), welcomed the work being done by the Strategic Advisory Group of Experts on immunization to develop indicators to monitor the progress being made at the country and global levels. Those indicators provided a useful basis but might have to be revised in future. She also welcomed the revision of the WHO/UNICEF guidance on developing national plans that took into account the targets and goals of the global vaccine action plan. The guidance would aid Member States in developing procedures for monitoring, evaluation and accountability at national level and would make it easier to agree on corresponding procedures at regional and global levels.

Dr DAULAIRE (United States of America) agreed with the proposed incorporation of multi-year costed immunization plans within broader national health system planning processes. High-level national commitment to collect accurate data and report annually was critical to monitoring and evaluating progress towards the goals and strategic objectives of the global vaccine action plan. While expressing support for the tracking of countries’ national immunization expenditures, and encouraging opportunities for synthesis and the leveraging of funds across broader national health system budgets, he suggested that some components of the implementation plan and indicators would require further refinement. For example, it would be important to identify how countries would use the results and how regional committee recommendations would be implemented. Standardization within and across countries would also be necessary, to allow for analyses over time and across different countries. For low- and middle-income countries that were not eligible for GAVI Alliance support, identifying financial resources would be critical for the implementation of the proposed framework. He encouraged WHO to be more ambitious in its goal to develop and introduce improved vaccines and technologies by 2020 and to concentrate more closely on issues related to the cost-effective delivery and affordability of the entire vaccination package. The Decade of Vaccines had reinvigorated the



discussion on the need for robust routine immunization programmes; he also commended its inclusion of the eradication of poliomyelitis and the accelerated progress it had generated towards the global goals of elimination of measles, rubella and neonatal tetanus.

Dr RATIH (Indonesia) said that, although the global vaccine action plan was an excellent strategic framework, guidance on monitoring, evaluation and accountability was vital to ensure its implementation by Member States. High immunization coverage and strong surveillance activities would contribute to achieving regional targets on the eradication of poliomyelitis and the elimination of maternal and neonatal tetanus and measles. There was increasing demand for new vaccines as a result of the Decade of Vaccines, and she urged manufacturers to provide vaccines at affordable prices, particularly for developing countries, and to facilitate access to production technologies.

Professor ARSLAN (Bangladesh) said that Bangladesh had achieved most of the global targets for routine immunization and vaccine-preventable disease control, with the introduction of vaccines against hepatitis B, *Haemophilus influenzae* type b and rubella; the pneumococcal vaccine would be introduced in August 2013 with the support of the GAVI Alliance. Several pharmaceutical companies were planning to produce vaccines in Bangladesh, and efforts were in hand to enhance the capacity of the national regulatory authority to monitor domestic production. As it would be difficult for Member States to obtain data on the strategic objective-level indicators on, for example, domestic expenditure per person targeted or confidence in vaccination at the subnational level, WHO should develop measurement tools and provide support to Member States in their use. He supported the proposed framework for monitoring, evaluation and accountability but suggested that WHO should refine the indicators to make them measurable by Member States.

Dr SEAKGOSING (Botswana) said that his country had developed a multiyear plan for the Expanded Programme on Immunization, aligned with the six guiding principles of the global vaccine action plan. The strategies and activities in the national plan included child health days, African Vaccination Week, supplementary measles immunization activities and the introduction of pentavalent, rotavirus and pneumococcal vaccines. He encouraged WHO, the GAVI Alliance and other stakeholders to continue providing support to Botswana and other countries by bringing about lower vaccine costs in order to ensure the sustainability of immunization programmes.

Dr YILMAZ (Turkey) said that despite measles elimination programmes, many countries, including developed ones, were encountering difficulties in eliminating the disease as a result of low vaccination coverage rates; anti-vaccine groups were having a significant impact on those rates. WHO should launch an initiative to combat the influence of anti-vaccine groups; measles elimination could only be achieved if everyone played his or her part.

**Dr Gwenigale resumed the Chair.**

Dr ABDULLA (Maldives) said that the global vaccine action plan was an important strategic document that would shape attainment of the goals of the Decade of Vaccines. Her country was committed to achieving global polio-free status and measles elimination in the next biennium. Monitoring of immunization coverage and preparedness against reintroduction of those diseases would be of utmost importance in that regard. The South-East Asia Region was actively working to achieve the goals of the global vaccine action plan, and all Member States had developed focused plans to reach the targets and increase immunization coverage. A regional immunization strategic plan would be finalized by the end of 2013. Significant resources at country level, often through external funding, and strong international support would be needed to implement that plan. The main challenge for Maldives, as a small, import-dependent country, was the procurement of vaccines; the rising costs and limited accessibility of some vaccines threatened successful implementation of its immunization

programme. She hoped that the global vaccine action plan would help to improve availability through appropriate price monitoring and controls.

Dr MARTÍNEZ DE CUELLAR (Paraguay) said that immunization was a priority in her country; in recent months, four new vaccines had been introduced, against varicella, hepatitis A, diphtheria, tetanus and pertussis, and human papillomavirus infection. Her country had gathered significant experience using a coordinated, multisectoral approach, working with the education sector to give the human papillomavirus vaccine to schoolchildren; a strategy had also been developed to reach children who did not attend school. Storage and transport capacity had been strengthened and a national registry developed. No case of measles, rubella or congenital rubella syndrome had been identified in the last 10 years. However, weaknesses persisted, and she requested the Secretariat to continue providing support to Paraguay and other countries for strengthening the monitoring of epidemiological and laboratory trends and enhancing community-based activities, so that immunization was recognized as a right and areas at risk were reached.

Professor MESBAH (Algeria) said that a workshop had been held in his country the previous month on updating the immunization schedule, so that the planned introduction of four new vaccines would be in line with WHO's recommendations. It was important that vaccines, including the most modern ones, were made available at a reasonable price. He was not seeking a charitably subsidized price, just a fair one; a vaccine supply mechanism for medium-income countries should be developed.

Dr RUÍZ MATUS (Mexico) said that when the vaccination scheme had started in his country, six vaccines had been included; that number currently stood at 14. It was important that WHO should urge Member States to continue strengthening mechanisms for ensuring safe vaccination practices.

(For continuation of the discussion, see the summary record of the tenth meeting, section 2.)

**The meeting rose at 17:30.**

## **TENTH MEETING**

**Saturday, 25 May 2013, at 09:35**

**Chairman:** Dr W.T. GWENIGALE (Liberia)

### **1. FOURTH REPORT OF COMMITTEE A: (Document A66/70)**

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

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

### **2. COMMUNICABLE DISEASES: Item 16 of the Agenda (continued)**

**Global vaccine action plan:** Item 16.1 of the Agenda (Document A66/19) (continued from the ninth meeting, section 2)

Mr BLAIS (Canada) acknowledged the significant progress made in operationalizing the global vaccine action plan, particularly the alignment of the proposed framework for monitoring, evaluation and accountability with the Accountability Framework for the United Nations Secretary-General's Global Strategy for Women's and Children's Health. He was in favour of adding an indicator for the price of vaccines to the framework and underscored the importance of ensuring equity if the benefits of immunization were to be fully realized.

Dr LEI Zhenglong (China) said that his country had maintained zero polio status in 2012, reduced the HBsAg carrier rate to less than 2%, and eliminated neonatal tetanus. He suggested stepping up promotion of the global vaccine action plan in order to attract more government attention and support. He also suggested strengthening grassroots immunization work; fostering technology transfer to developing countries; guaranteeing local production of inactivated poliovirus vaccine; harmonizing and reducing vaccine prices; and supporting Member States in the formulation of relevant policies, with an emphasis on data collection and analysis, in order to promote evidence-based decisions on the use of vaccines.

Dr DE ROSAS-VALERA (Philippines) said that, as the first country in the Western Pacific Region to have introduced rotavirus vaccines into its expanded immunization programme, the Philippines was also strengthening its vaccine vigilance system. Noting that immunization was a public good, she urged the Secretariat to support the efforts of low- and middle-income countries to procure vaccines at more affordable prices and to conduct analyses of the cost-effectiveness of other health technology interventions. She encouraged Member States to share their studies on the cost-effectiveness of vaccines.

Professor Pei-Jer CHEN (Chinese Taipei) said that, in accordance with the global vaccine action plan, Chinese Taipei had established a comprehensive immunization programme, a vaccine fund for

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<sup>1</sup> See page 310.

the purchase of new vaccines and an advisory committee on immunization practices. The 13-valent pneumococcal conjugate vaccine had been introduced for children aged between two and five years of age and would be incorporated into routine childhood immunization in 2014. Unstable supplies of some composite vaccines over the previous two years had nevertheless caused scheduling and compatibility problems, which had an impact on disease prevention. He therefore urged WHO to secure greater commitment from stakeholders and to harmonize vaccine manufacturing in order to stabilize vaccine supplies.

Ms SLOATE (GAVI Alliance), speaking at the invitation of the CHAIRMAN, said that the GAVI Alliance's programmes were central to the success of the global vaccine action plan. A massive acceleration was under way in the roll-out of several vaccines. Over the previous decade the number of countries using the pentavalent vaccine, for example, had risen from seven to 70, resulting in more secure supplies and significantly lower prices. New pneumococcal and rotavirus vaccines were being introduced in developing countries. The sharp rise in the number of countries using those vaccines demonstrated the importance of national leadership and of the country-driven approach inherent in the global vaccine action plan. The combined measles-rubella vaccine would be introduced in 49 countries by 2020 and there was high demand in developing countries for the human papillomavirus vaccine. Nevertheless, although coverage rates were climbing, one in five children was not immunized. The GAVI Alliance strongly supported the proposed monitoring framework and stood ready to play an integral part in its implementation.

Dr BIGGER (International Federation of Pharmaceutical Manufacturers and Associations), speaking at the invitation of the CHAIRMAN, said that meeting vaccination coverage targets and sustaining the use of vaccines over the next decade would prevent millions of deaths and generate many billions of dollars in health care savings. The Federation had helped to develop vaccines for diseases originally considered to be non-preventable and had worked with the GAVI Alliance to improve access to vaccines and upgrade immunization services. Vaccines to reduce the burden of cervical cancer, pneumonia, meningitis and rotavirus disease were available globally, and more than 200 vaccines were being developed for preventable diseases such as dengue, cholera, malaria and tuberculosis. The success of the global vaccine action plan would depend on a holistic approach to vaccine access, balancing considerations of availability and continuity of supply. It was also important to maintain research and development incentives in order to foster innovation. Greater recognition by policy-makers and communities of the broad socioeconomic benefits of immunization would encourage investment, and governments should raise awareness of those benefits. The Federation fully supported the global vaccine action plan.

Ms ELDER (MSF International), speaking at the invitation of the CHAIRMAN, expressed concern that the proposed framework for monitoring, evaluation and accountability under the global vaccine action plan omitted two essential targets. First, the framework was not ambitious enough, and the target of one new platform delivery technology by 2020 should be increased to five. Secondly, Member States should insist on the inclusion in the framework of indicators to track vaccine prices, which had risen by 2700% since 2001, bearing in mind that greater affordability was one of the key goals of the Decade of Vaccines. The disproportionately high cost of the newest vaccines had a direct impact on MSF International which, under GAVI Alliance policy, was denied access to GAVI-negotiated prices. Indeed, MSF International, like other nongovernmental organizations, was not able to participate in price negotiations and was thus prevented from fulfilling health ministry requests to help countries vaccinate their most vulnerable children.

Mr KANWAGI (World Vision International), speaking at the invitation of the CHAIRMAN, recalled that the report from the Global Thematic Consultation on Health in the post-2015 United Nations development agenda had concluded that development goals should emphasize health enablers such as immunization. The persistence of coverage gaps between and within countries meant that

millions of children born each year remained unimmunized or incompletely immunized, especially in lower-middle-income countries that were not eligible for GAVI Alliance support or preferential pricing. His organization therefore called on Member States to ensure funding for lower-middle-income countries to provide complete immunization for all women and children, intensify efforts to reduce the drop-out rate, and ensure that indicators related to the fully immunized child were included in the post-2015 development agenda.

Mrs BARRIA (Medicus Mundi International – International Organisation for Cooperation in Health Care), speaking at the invitation of the CHAIRMAN, expressed concern that the proposed framework for monitoring, evaluation and accountability did not provide for indicators related to specific vaccination targets that took account of the social, economic and environmental determinants of health. Noting with concern the pressures on countries to adopt a uniform global schedule of immunization, she said that the cost-effectiveness of vaccines and immunization campaigns should be evaluated on a case-by-case basis by the individual countries concerned, with WHO support. In addition, the global vaccine action plan did not give due weight to the development of vaccine research and production technology in developing countries, and failed to mention the importance of technology transfer and the need to strengthen health systems in order to ensure delivery of immunization services. The availability of donor funding for vaccination, while other important areas of work languished for want of funds, illustrated the dangers of WHO's over-reliance on donor funding.

Dr BUSTREO (Assistant Director-General) expressed appreciation for Member States' commitment and actions to strengthen routine immunization and related support systems, as well as for the progress made towards the goals of eradicating poliomyelitis and eliminating neonatal tetanus. Although there had been some setbacks in meeting measles elimination targets, the global response to the recent outbreak had been swift and effective. There had been increased momentum towards achieving coverage with three doses of diphtheria-tetanus-pertussis vaccine and introducing the new vaccine. She thanked Member States for introducing pneumococcal and rotavirus vaccines, which should lead to significant progress in reducing the under-five mortality rate in line with Millennium Development Goal 4 and the objectives of the global vaccine action plan.

She welcomed Member States' endorsement of the proposed framework for monitoring, evaluation and accountability. Because it was closely aligned with the Accountability Framework for the United Nations Secretary-General's Global Strategy for Women's and Children's Health, progress on immunization would be considered within the broader context of women's and children's health and health system strengthening. The annual independent review process and reporting to the WHO governing bodies would provide an opportunity to monitor progress and hold the relevant stakeholders accountable. The targets were intended to be ambitious but not unrealistic; they should not overburden countries and they would make use of existing reporting systems. The working group of the Strategic Advisory Group of Experts on immunization, which was monitoring implementation of the global vaccine action plan, would be apprised of the valuable comments made by the delegates of Canada, Thailand and the United States of America about improving the proposed set of indicators. Regarding the issue of access to affordable vaccines, she pointed out that the prices of vaccines varied according to countries' income levels and their different procurement mechanisms. As a result, the determination of a single indicator to monitor the affordability of vaccines had thus far proved challenging. A special working group had been established to study that issue more closely and the 2014 progress report to the governing bodies would include an assessment of trends in vaccine prices. Noting Member States' request that the Secretariat continue to provide support for the immunization programme and the associated actions defined in the plan, she said that the Director-General fully supported that request and would continue to ensure that efforts across all teams, regions and partners were enhanced and accelerated.

**The Committee noted the report.**

**Neglected tropical diseases:** Item 16.2 of the Agenda (Documents A66/20 and EB132/2013/REC/1, resolution EB132.R7)

The CHAIRMAN drew attention to the draft resolution recommended by the Executive Board in resolution EB132.R7.

Dr MOHAMED (Maldives, representative of the Executive Board) said that, at its 132nd session, the Executive Board had considered the report on neglected tropical diseases. During the discussions, Members had highlighted the need to scale up control, elimination and eradication measures in countries where neglected tropical diseases were endemic and had called for strengthened country capacity. The Board had recommended to the Sixty-sixth World Health Assembly the adoption of the revised draft resolution incorporating amendments proposed by Member States, as contained in resolution EB132.R7.

Dr AL-TAAE (Iraq) said that Member States and the Secretariat should collaborate on epidemiological and laboratory surveillance activities related to all neglected tropical diseases, focusing in particular on vector, entomological and geographical surveillance and pharmacovigilance. Operational research was needed on all such diseases that presented a similarity of risk factors. He stressed the importance of sharing expertise and building capacity at the national level, as well as within and between regions, with support from WHO.

Dr ETOUNDI MBALLA (Cameroon), speaking on behalf of the Member States of the African Region, commended the Secretariat's work on neglected tropical diseases, which was reflected in the draft resolution. Noting that some 50% of all persons affected by such diseases lived in Africa, he said that national programmes in the Region focused on strategic public health interventions to enhance the efficiency and effectiveness of prevention, control, elimination and eradication activities. In order to finance those activities, additional resources had been allocated through national budgets, together with generous donor funding from the international community, for which he expressed particular appreciation. As a result, considerable progress had been made over the previous 10 years. However, a number of challenges remained, including the continued inadequacy of national budget allocations. It was also necessary to direct resources to countries and areas with high morbidity and mortality rates; to improve the visibility of programmes on neglected tropical diseases at both national and international levels; to enhance effective intersectoral collaboration; and to ensure integrated surveillance and follow-up of the progress and impact of health system interventions. His Region therefore fully supported the draft resolution, in particular its emphasis on community-based interventions, coordinated funding and the need for an integrated approach to control programmes, where feasible, in order to achieve greater coverage and reduce operational costs.

Dr LOKMAN HAKIM SULAIMAN (Malaysia), while expressing support for the draft resolution, called for greater attention to be paid to dengue, the global incidence of which had increased dramatically in recent years. There was no effective vaccine for dengue and no effective medication to treat it; vector control strategies were the only available option and even those were fraught with challenges. In view of the global importance of dengue and its effect on the lives of many populations, the member countries of ASEAN observed ASEAN Dengue Day on 16 June every year and dedicated significant resources to dengue-control activities, the results of which had thus far proved disappointing. Global investment in dengue research and development must be enhanced in order to identify and develop effective, practical and affordable surveillance, diagnostic, treatment, prevention and control tools. Those tools would also be needed to implement the recommendations contained in paragraph 18 of the report and in the draft resolution. Without urgent, coordinated action spearheaded by the Organization and the UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases, dengue might become the most important global health problem in the next decade.

Dr KAFA (Solomon Islands) said that his country continued to be affected by the re-emergence and reinfection of several neglected tropical diseases, including the current outbreak of dengue haemorrhagic fever, the scale of which was considerable in relation to the size of the population. He thanked WHO and development and donor partners for their technical and financial support during the outbreak. The Secretariat must continue to support health system strengthening in Member States, to prevent, control, eliminate and eradicate neglected tropical diseases as well as to alleviate poverty. Acknowledging that a common, integrated approach was needed to prevent and control neglected tropical diseases, he endorsed the principle, as defined in the WHO road map to accelerate work on neglected tropical diseases and the London Declaration on Neglected Tropical Diseases, that prevention and control activities should form an integral part of universal health coverage. He fully endorsed the draft resolution.

Mr HIRAOKA (Japan) said that the WHO road map to accelerate work on neglected tropical diseases defined clear but achievable targets for 2015 and 2020 and incorporated a range of disease control strategies into one clear framework. He congratulated the Secretariat and the expert working groups on developing the road map and hoped that it would be used effectively by Member States. Clarification of the roles and responsibilities of the UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases would promote synergy between the Special Programme and the Secretariat's Department of Control of Neglected Tropical Diseases, in order to provide effective support for control activities at global, regional and country levels.

Mr GAYIPOV (Turkmenistan) said that his country was committed to supporting global efforts to combat neglected tropical diseases and had taken steps towards the goals set out in the London Declaration on Neglected Tropical Diseases. Commending WHO's support for eradication and elimination efforts, he endorsed the draft resolution and urged other Member States to do the same.

Dr CICOONA (Italy) said that current and future activities in the area of neglected tropical diseases, including those in the post-2015 United Nations development agenda environment, should be built on solid, robust technical systems and guided by the clear and well-balanced WHO road map to accelerate work on neglected tropical diseases. Noting the link between those diseases and social justice, he remarked on their disproportionate effect on women and children and their adverse impact on poverty and the socioeconomic development of populations. He fully supported and wished to sponsor the draft resolution.

Dr SMIRNOVA (Russian Federation), noting the link between neglected tropical diseases and poverty, said that remedial action must focus primarily on socioeconomic development and universal access to health care. She underscored the importance of preventive measures and enhancing access to safe drinking-water and sanitation. Her country had welcomed the adoption of the London Declaration on Neglected Tropical Diseases and was committed to meeting its obligations thereunder. Disease-endemic countries should incorporate strategic planning measures into their national programmes, ensure adequate financing for the implementation of preventive measures, the provision of health care and epidemic surveillance, and establish a comprehensive monitoring and control framework. In recent years, her Government had invested in work to combat neglected tropical diseases, including the development of laboratories and the training of medical health professionals, as well as support to developing countries. She endorsed the draft resolution.

Dr FREDERICKS-JAMES (Saint Lucia) expressed support for the draft resolution. The frequency of dengue outbreaks, including dengue haemorrhagic fever and dengue shock syndrome, had recently increased in the member countries of the Caribbean Community. Observing that leprosy and schistosomiasis were still present in her country, she said that Saint Lucia and other disease-endemic countries of the Caribbean Community would welcome additional support from

PAHO in their efforts to eradicate those and other neglected tropical diseases. She also looked forward to forthcoming support from the Caribbean Public Health Agency.

Ms RIGHETTI (Switzerland), endorsed the draft resolution and commended the WHO road map to accelerate work on neglected tropical diseases and related initiatives, such as the London Declaration on Neglected Tropical Diseases. Given the disproportionate impact of neglected tropical diseases on the poor, her country was actively engaged in efforts to achieve the targets set out in the WHO road map. It was important to ensure that adequate financing mechanisms were established to support the development of new treatments. She pointed out that preventive measures, and measures to combat stigmatization and mental health issues caused by neglected tropical diseases, were equally as important as control, elimination and eradication measures. In that connection, she encouraged Member States to step up country-level prevention programmes, including through the provision of safe drinking-water and sanitation, health promotion and education, and community participation. Neglected tropical diseases must be integrated into the package of essential primary health care services.

Dr SADRIZADEH (Islamic Republic of Iran) said that neglected tropical diseases mostly affected the poor and underprivileged in low-income countries and thus often failed to attract the necessary attention from high-level decision-makers and politicians. In addition, the lack of a profitable market deterred academic and research institutions and the pharmaceutical industry from developing relevant diagnostic tools, medicines and vaccines. However, the WHO road map to accelerate work on neglected tropical diseases had successfully mobilized global multisectoral action. He called for the implementation of a wide range of measures to address the remaining challenges, including ensuring country ownership of programmes; allocating adequate resources; integrating control programmes into primary health care services; advocating predictable, long-term international financing, and strengthening national monitoring and evaluation capacity.

Ms ORTEGA CRESPO (Spain) expressed support for the draft resolution. The prevention and control of neglected tropical diseases was an integral component of universal health coverage and required both solid, effective health systems and multisectoral engagement. Access to the knowledge and innovations generated through research should be facilitated and the production, availability and sustainable provision of quality medicines should be ensured. Her country was engaged in a range of global and regional initiatives aimed at discovering and developing new vector control products, diagnostic tools and medicines and promoting innovative research. Spain was also involved in a number of bilateral programmes to strengthen health systems, especially in relation to the management and monitoring of national prevention, control and awareness-raising programmes in order to break the link between disease and poverty. In addition, her country had established an epidemiological surveillance programme to prevent and control congenital transmission of Chagas disease and was collaborating closely with a number of signatories to the London Declaration on Neglected Tropical Diseases in that connection. In view of its knowledge, technical experience and links with Latin America, Spain could play an important role in the fight against neglected tropical diseases and would continue to offer its support.

Dr LEI Zhenglong (China) expressed support for the comprehensive draft resolution, which would guide global efforts to prevent, control, eliminate and eradicate neglected tropical diseases. All countries, particularly those that bore a heavy burden of neglected tropical diseases, should incorporate prevention and control measures into their national strategies and strategic planning. Observing that the Secretariat should coordinate the sharing of experience and best practices among Member States, he said that China stood ready to share its experience in tackling neglected tropical diseases, especially its efforts to prevent and control schistosomiasis.



Dr LANE (United Kingdom of Great Britain and Northern Ireland) expressed strong support for the draft resolution. His Government had invested heavily in programmes to tackle neglected tropical diseases and had been honoured to host the January 2012 meeting at which the London Declaration on Neglected Tropical Diseases had been adopted. Expressing appreciation for the establishment of national commitments by disease-endemic countries, he welcomed in particular the African Region's commitment to increase national funding for neglected tropical diseases and health care in general. His country looked forward to continuing its collaboration with the Secretariat and all Member States in the control and future elimination of neglected tropical diseases.

Dr BUSUMANI (Zimbabwe) noted with concern that the draft resolution contained references to the London Declaration on Neglected Tropical Diseases, which had not been endorsed by all Member States, but did not acknowledge in the work done on developing the Global Plan to Combat Neglected Tropical Diseases 2008–2015. He also expressed concern at the possible influence of industrial vested interests in that regard. He therefore recommended that the draft resolution should contain references only to the WHO road map to accelerate work on neglected tropical diseases and the action agreed to by Member States.

Mr ELMARDI (Sudan) expressed appreciation of WHO's efforts to control and eradicate neglected tropical diseases and thanked donors and partners for their support. Highlighting the devastating impact of mycetoma, which mostly affected poor populations, he remarked that his country had organized a side event on that disease, jointly with the Drugs for Neglected Diseases initiative, at the current Health Assembly.

Mr RAZAFINDRAZAKA (Madagascar) said that his country's actions to combat neglected tropical diseases were carried out at both national and district levels and focused on communicable diseases; they included a campaign for the distribution of generic medicines. However, in view of Madagascar's limited resources, which were already stretched by the double burden of communicable and noncommunicable diseases, additional support from international health partners would be welcomed. Noting that neglected tropical diseases mostly affected developing countries, he said that technical support was required from WHO and financial support from international health partners. He supported the draft resolution.

Dr BLOKLAND (Suriname) said that his country had developed a draft action plan with the support of PAHO and WHO to combat neglected tropical diseases, including schistosomiasis, leprosy, intestinal helminth infections, leishmaniasis and Chagas disease. The success of the plan would depend on the implementation of surveys, the strengthening of surveillance, and the availability of diagnostic tools, and in that connection continued technical and financial support from WHO was needed. He expressed support for the draft resolution.

Mr HIEN (Burkina Faso) drew attention to the increasing incidence of noma, which mainly affected children from disadvantaged communities in developing countries as a result of malnutrition and poor oral hygiene. A national programme to combat noma, in operation since 2002 had received technical and financial support from the Winds of Hope Foundation, WHO and several nongovernmental organizations and associations, but no reliable data existed on the national prevalence and incidence of the disease. He recommended the inclusion of noma in the list of neglected tropical diseases under consideration by the Organization and thanked the permanent missions of various African Member States for their work in support of that goal.

Mr DESIRAJU (India), speaking on behalf of the Member States of the South-East Asia Region, said that tropical diseases, which were diseases of the poor, had been neglected in terms of policy support, prioritization, resource allocation and effective implementation. Leprosy, lymphatic filariasis, leishmaniasis and dengue in particular were major public health problems in his Region, and

yaws was a focalized problem in India, Indonesia and Timor-Leste. A five-year regional strategic plan had been launched in 2012; some countries were on track to achieve regional and global targets; and further impact goals had been included in WHO's Twelfth General Programme of Work. Given the proposed reduction in budget allocations to the Regional Office for communicable diseases and preparedness, surveillance and response, however, additional resources would have to be mobilized.

Turning to the draft resolution, he said that greater emphasis should be placed on dengue in view of the increasing global impact of that disease. Furthermore, the repeated references to the London Declaration on Neglected Tropical Diseases were inappropriate, as it had not arisen from a process involving the participation of Member States; they should be replaced by references to the Global Plan to Combat Neglected Tropical Diseases 2008–2015. He proposed that the word "continued" should be inserted in subparagraph 1(1), between "to ensure" and "country ownership"; the words "taking into account social determinants of health" should be inserted in subparagraph 1(5)(c), after "neglected tropical diseases"; the word "discovery" in subparagraph 2(2) should be replaced by "research"; and the word "insecticides" in subparagraph 3(5) should be replaced by "vector control measures". Subject to those proposed amendments, the Member States of his Region would support adoption of the draft resolution.

Dr ABDULLA (Maldives) said that, although leprosy had been brought under control in Maldives and lymphatic filariasis was close to elimination, dengue remained a major challenge on account of the need for intensive management. Despite being targeted in WHO's road map to accelerate work on neglected tropical diseases, the global incidence of dengue had increased dramatically, putting 40% of the world's population at risk, and its control called for adequate levels of funding and a multisectoral approach with extensive community participation. Her delegation therefore expressed concern about the inadequate priority given to the disease in the draft resolution.

Meanwhile, countries that had met their targets to eliminate and control neglected tropical diseases must remain alert to their possible reintroduction, which called for stringent monitoring, preparedness and response, and the development of strong, multi-stakeholder, cross-border collaboration at the regional and global levels.

Dr MALECELA (United Republic of Tanzania) welcomed the draft resolution. Several neglected tropical diseases were highly endemic in his country and in others in the Region, and the resolution could accelerate the significant progress already being made towards their elimination. Sufficient resources had to be made available to ensure the success and sustainability of integrated national programmes, which should be carried out in conjunction with other development efforts.

Ms CALDERÓN DE COPETE (Panama) strongly supported the draft resolution. Cutaneous leishmaniasis was endemic in parts of her country and, although the preferred treatment with pentavalent antimonials was effective, they had a number of pharmacological disadvantages, and treatment was often abandoned on grounds of pain. Efforts to control the disease included laboratory-based diagnosis; timely provision of treatment to affected populations; enhanced epidemiological surveillance in endemic areas, and awareness-raising for health professionals. Her Government was in the process of updating its guidelines with the support of PAHO and would continue sharing its experience with others.

Dr SAOWAPAK HINJOY (Thailand) said that neglected tropical diseases were pushing people deeper into poverty even though the cost of treatment was relatively low.

She supported the draft resolution. To emphasize the need for countries close to eradicating a disease to remain committed to continuing surveillance, however, a new subparagraph 1(1)*bis* should be added, to read: "to further strengthen the disease surveillance system especially on neglected tropical diseases targeted for eradication;". Furthermore, given that the control of tropical diseases called for a multidisciplinary approach and effective implementation of the One Health concept,

subparagraph 1(5)(c) should end with the following additional wording: “with the application of the One Health concept to neglected tropical diseases and effective coordination across different sectors;”.

Dr DE ROSAS-VALERA (Philippines) said that neglected tropical diseases prevented many poor people in her country from leading healthy and productive lives, and that most of those affected lived in hard-to-reach, resource-poor communities. Her Government was committed to implementing programmes for the prevention, control and elimination of those diseases, deriving guidance from WHO and the London Declaration on Neglected Tropical Diseases. It was in the process of developing context-specific policies, standards and guidelines, in conjunction with actions to combat other high-priority diseases, and it would continue to scale up its efforts in the areas of resource mobilization, capacity-building, research and intersectoral partnerships, among others. The improvement of water and sanitation services would be one of the key factors in that regard. She fully supported the draft resolution and the amendments proposed by the delegates of India and Thailand.

Ms LÓPEZ DE LLERGO CORNEJO (Mexico) said that Mexico had made significant advances in the prevention, control and elimination of neglected tropical diseases such as rabies, leprosy and onchocerciasis, but that more needed to be done to combat dengue, Chagas disease and leishmaniasis. Her Government would continue to promote the participation of affected communities and civil society as a whole, and regarded the support of WHO and PAHO as a key element of success. She endorsed the draft resolution.

Dr HO (Brunei Darussalam), commending WHO’s emphasis on the need for collective action to combat neglected tropical diseases, said that Brunei Darussalam was committed to the global goal of eradicating those diseases by 2020 and supported the draft resolution. Her Government had embarked on a programme to eliminate lymphatic filariasis, which persisted in small pockets of the population, and supported the proposal of Saint Lucia and Member States of the South-East Asia Region to tackle the problem of dengue, reported cases of which had increased fivefold in Brunei Darussalam in the previous year. Other mosquito-borne diseases such as chikungunya should also be taken into consideration.

Mr KLEIMAN (Brazil) stressed the need to strengthen national health systems, especially at the primary care level, and to mainstream health-related measures into social and economic policies aimed at eliminating extreme poverty, in order to break the link between neglected tropical diseases and poverty. Particular emphasis should be placed on capacity-building, research and development incentives, and transfer of technology to developing countries. Brazil was stepping up efforts to combat diseases such as visceral leishmaniasis, and had recently launched a national campaign for the detection and treatment of leprosy and helminthiasis.

Expressing appreciation for WHO’s leadership and for the road map to accelerate work on neglected tropical diseases, he said that the world needed a strong alliance to move the agenda forward, in line with implementation of the Global Plan to Combat Neglected Tropical Diseases 2008–2015. He therefore proposed adding a new preambular paragraph to the draft resolution, before the second preambular paragraph, with the following wording: “Recognizing the importance of the Global Plan to Combat Neglected Tropical Diseases 2008–2015;”. Furthermore, in subparagraph 1(2), the words “by all partners in” should be replaced by “in the Global Plan to Combat Neglected Tropical Diseases 2008–2015, taking into account”. Brazil supported the amendments proposed by the delegate of India and emphasized the importance of approving the draft resolution.

Dr NABEEL (Pakistan) expressed support for efforts aimed at the prevention, control and elimination of neglected tropical diseases, especially leishmaniasis, parasitic diseases and dengue. The latter was a significant public health problem in Pakistan, and vigorous and effective measures had been taken to tackle the recent outbreak. Thanking WHO for its support, he urged the Organization to

increase its emphasis on the disease and to continue its leadership role in promoting the necessary enhanced partnerships.

Dr NSAKASHALO SENKWE (Zambia) commended and supported the draft resolution, which provided a framework for leveraging resources to eliminate such diseases through the engagement of relevant stakeholders. Her country was plagued by lymphatic filariasis, however, and she was concerned about pharmaceutical companies withholding donations of ivermectin on the grounds that onchocerciasis was not endemic in Zambia. She therefore urged WHO to engage those companies so as to assist it in meeting the goal of eliminating the disease by 2020.

Ms GÓNGORA TORRES (Colombia) drew attention to the fact that her Government's 10-year public health plan included actions for the prevention and control of neglected tropical diseases such as trachoma, Chagas disease and soil-transmitted helminthiasis, as part of its programme focusing on risk factors and the social determinants of health. Targets for eliminating morbidity and interrupting the transmission of onchocerciasis had been met through continuous work with local authorities and communities in isolated, hard-to-reach areas.

She supported the draft resolution and the amendments proposed by Brazil and the Member States of the South-East Asia Region. Particular emphasis should be placed on enhanced coordination for the development of effective and affordable technologies, and WHO should strive to make further progress in disseminating the criteria for the elimination of trachoma; in expanding the list of neglected tropical diseases; in developing guidelines and in focusing attention on and prioritizing dengue, given its increasing prevalence in countries most affected by climate change and extreme weather conditions.

Ms GIBB (United States of America) supported the draft resolution. Recognizing that achievement of the goals for 2020 outlined in the WHO road map to accelerate work on neglected tropical diseases would depend on more rapid treatment of those diseases through integrated country-level programmes, she called for more attention to be paid to capacity-building and implementation at country level. Furthermore, she recommended that the Secretariat should take steps to finalize its critical disease-specific guidelines. She had no objection to the amendments proposed by the delegates of India and Brazil but could not accept those proposed by the delegate of Thailand, as they were extensive and introduced new concepts proposed at the last minute.

Professor Pei-Jer CHEN (Chinese Taipei) said that his delegation would welcome the adoption of the draft resolution. Although certain tropical diseases had been brought under control in Chinese Taipei, following improvements in general hygiene and medical resources, dengue was an emerging challenge requiring effective vector control and case management. The elimination of mosquito breeding sites had been adopted in Chinese Taipei as the main vector-control measure. There was also greater collaboration at the local level and use of trained community volunteers in the implementation of preventive strategies. In the previous decade, fever screening at international airports and seaports in Chinese Taipei had helped detect about half of all imported dengue cases. In order to achieve effective control of dengue, however, a safe vaccine was needed.

Dr KNOPF (The Global Alliance for Rabies Control Inc.), speaking at the invitation of the CHAIRMAN, said that rabies caused about 60 000 preventable human deaths per year, more than any of the other neglected tropical diseases. The majority of rabies victims were children and marginalized populations in rural areas of Asia and Africa. The disease had been brought under control in some parts of the world but was still endemic in others owing to underreporting, misdiagnosis and scarce resources. Tools for the prevention of the disease were available and its elimination was feasible. Greater collaboration between stakeholders and the development of several regional road maps for rabies elimination had contributed to recent progress in combating the disease. The Alliance was working with WHO on a global strategy for the elimination of canine-mediated human rabies by 2030.

Mr OTTIGLIO (International Federation of Pharmaceutical Manufacturers and Associations), speaking at the invitation of the CHAIRMAN, said that continued leadership by WHO was fundamental to winning the fight against neglected tropical diseases. The pharmaceutical industry was actively researching and developing medicines for treating those diseases and was increasing access to treatment through medicine donation programmes. Within the framework of the London Declaration on Neglected Tropical Diseases, the industry had undertaken to donate 14 billion treatments by 2020 to control or eliminate nine major neglected tropical diseases. In addition, the industry had entered into partnerships with other stakeholders to strengthen health system capacity and had increased the number of research and development programmes by 40% within the past year. Industry efforts were not sufficient by themselves, however; improved sanitation, access to safe water, education and investment in health systems required the engagement of all health stakeholders, particularly governments.

Miss IVERSEN (International Federation of Medical Students' Associations), speaking at the invitation of the CHAIRMAN, welcomed the recognition reflected in the draft resolution that action was required to tackle the root causes of disease, including environmental, social, economic and political factors. Access to clean water, education and primary health care facilities needed to become realities on the ground. Drug donation programmes covered at most 10 neglected tropical diseases, while innovative solutions were still needed for others, including Chagas disease, leishmaniasis and human African trypanosomiasis. Global investment in research and development for neglected diseases was dwarfed by their global burden. There was an urgent need for innovative approaches that were aligned with public health priorities. Action on neglected tropical diseases was inextricably linked to the follow-up of the report of the Consultative Expert Working Group on Research and Development: Financing and Coordination. She urged Member States to support open knowledge innovation that produced global public goods for preventing, diagnosing and treating the neglected health needs of the poor.

Mr COMMAR (The Royal Commonwealth Society for the Blind (Sightsavers)), speaking at the invitation of the CHAIRMAN, said that the draft resolution added to the positive momentum generated by the London Declaration on Neglected Tropical Diseases and the WHO road map to accelerate work on neglected tropical diseases. It also demonstrated the recognition that increased investment in neglected tropical diseases had improved health and social well-being in many countries. Partnership and collaboration, involving governments, nongovernmental organizations, donors and pharmaceutical companies, must form the bedrock of efforts to end neglected tropical diseases. Programmes must target the poorest and most marginalized populations and tackle structural determinants, in particular water, sanitation and hygiene services, in order to achieve lasting change. Neglected tropical diseases were diseases of poverty; their elimination would contribute to greater economic productivity and reduce social inequalities.

Ms VELLEMAN (WaterAid), speaking at the invitation of the CHAIRMAN, said that in order to reach the ambitious elimination targets set for many of the neglected tropical diseases, efforts must go beyond the traditional approaches that relied on medical interventions. The draft resolution was a key step in that direction. There had been insufficient and uneven progress with respect to water, sanitation and hygiene, which were crucial to the prevention, control and elimination of neglected tropical diseases. About one third of the world's population did not have access to adequate sanitation. Greater coordination between Member States was needed in order to reduce transmission of neglected tropical diseases and reach the poorest and most marginalized communities, who carried the heaviest burden of disease and lacked access to basic services. She urged WHO to embed water, sanitation and hygiene in its disease control plans and strategies, to encourage all stakeholders to work together and to channel resources in such a way as to encourage collaboration.

Dr NAKATANI (Assistant Director-General) expressed appreciation of speakers' comments and their general support for the draft resolution. Neglected tropical diseases affected the poorest of the poor, and survivors often suffered from deformities and disabilities that gave rise to social stigma and discrimination. Issues relating to those diseases should therefore be considered from the three angles of health, development and human rights.

Although there was no licensed dengue vaccine, research was ongoing and clinical trials were under way. The Strategic and Technical Advisory Group for Neglected Tropical Diseases had concluded that existing tools could be used to reduce deaths from dengue by 50% and morbidity by 25%. WHO's global strategy for dengue prevention and control, comprising the four components of vector control, emergency response, case management and surveillance, treated dengue as a serious global problem, affecting countries with a variety of climates.

Following a strategic realignment process, the secretariat of the UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases had become smaller but more focused. The role of the WHO Programme Secretariat was to advise Member States on evidence-based norms and standards and global statistics, while that of the Special Programme was to generate evidence and build country capacity. The Special Programme's integration with the neglected tropical diseases department was fully reflected in the Programme budget 2014–2015. Noting that it was unrealistic to expect individual Member States to have access to specialists for every disease, he stressed that integration was central to the Organization's approach to neglected tropical diseases.

Responding to comments on the importance of improving health systems and access to quality-assured medicines, he said that partnerships involving Member States, the Secretariat, industry and other development partners were crucially important. Industry partners supplied massive amounts of medicines in support of that work.

Referring to disease-specific issues, he said that, although each country had its own unique epidemiological situation, the approach adopted should be one that promoted synergies while remaining country-focused. Leprosy, for example, had been eliminated as a public health problem (except in one country), but there were a few hot spots requiring action on a case-by-case basis. In response to the concerns raised by the delegate of Zambia, he said that, of the two medicines used in the treatment of lymphatic filariasis, ivermectin was only provided in areas where onchocerciasis was also endemic, which was not the case in Zambia. However, one manufacturer of diethylcarbamazine had agreed to provide the medicine starting in 2014.

The DIRECTOR-GENERAL said that her commitment to neglected tropical diseases dated back to her previous role as Assistant Director-General for Communicable Diseases. She had been struck by the scale of the problem and the silent suffering of more than 1 billion faceless and voiceless victims, who struggled with inequality and social stigma associated with the diseases. Although some of the medicines necessary for treating the diseases only cost pennies, the poorest of the poor could not afford them. The resulting market failure, arising from the lack of demand and the lack of supply, posed a major challenge, as did the limited capacity of overwhelmed health systems and the limited awareness of the problem in some Member States.

Neglected tropical diseases had been a priority for the Organization from the beginning of her tenure as Director-General. Without tackling neglected tropical diseases, Member States could not celebrate Millennium Development Goal achievements. Having witnessed the ways in which countries grouped certain diseases together in order to combat them more effectively, she had concluded that a new approach to public–private partnerships was needed. Such partnerships required the support, leadership and commitment of Member States, the input of the world's researchers and the support of major pharmaceutical companies. The meeting that had produced the London Declaration on Neglected Tropical Diseases had been a watershed event, at which pharmaceutical companies had been challenged to collaborate in providing continuous donations of medicines, engage in technology transfer and make long-term commitments. Donations in 2010 and 2011 had totalled US\$ 94 million and were expected to reach US\$ 150 million in 2014 and 2015. Such long-term commitments enabled

the Secretariat to step up its ability to build health system capacities and support Member States in their efforts to deliver medicines to people living in remote areas.

Recognizing the importance of North–South and South–South collaboration, WIPO had established a new open access platform for innovation to promote collaboration between Member States, industry representatives and scientific institutions. WHO had been unable to join the initiative because of conflict-of-interest concerns, but Member States were encouraged to do so.

She urged Member States to provide further advice and guidance on follow-up of the report of the Consultative Expert Working Group on Research and Development: Financing and Coordination and on ways to redress the injustices affecting the victims of neglected tropical diseases.

Dr LANE (United Kingdom of Great Britain and Northern Ireland) commended the Director-General’s remarks concerning the importance of the meeting at which the London Declaration on Neglected Tropical Diseases had been adopted. He was anxious that the draft resolution should not be opened up to a lengthy redrafting process but was willing, in a spirit of compromise, to accept the amendment concerning the London Declaration proposed by the delegate of Brazil. Noting the concerns expressed by the delegate of the United States of America with respect to the amendments proposed by the delegate of Thailand, which contained important points, he suggested that they could be redrafted to make them more acceptable and to ensure that they did not introduce new concepts.

Professor HALTON (Australia) noted with appreciation and supported the passionate and eloquent statement made by the Director-General. Concerning the extensive amendments proposed by the delegation of Thailand, which contained new concepts of some complexity, she aligned herself with the remarks made by the delegate of the United States of America. On the other hand, in the interests of moving forward on the item, she was willing to accept the minor and helpful amendments proposed by the delegates of India and Brazil.

Dr THAKSAPHON THAMARANGSI (Thailand) said that the amendments proposed by his delegation were minor and did not introduce new concepts. The new subparagraph 1(1)*bis* proposed by his delegation contained wording of a general nature that could not be construed as objectionable. The amendment to subparagraph 1(5)(c) concerned safe drinking-water, basic sanitation, health promotion, vector control, and veterinary and public health, all of which were aspects of key importance for tackling neglected tropical diseases. His delegation strongly believed that environmental, animal and human health should be considered together under the heading of One Health, which was not new to the Health Assembly: in 2008 WHO, together with FAO and OIE, had produced a report on the subject. He proposed changing the wording of the second proposed amendment, so as to add, at the end of subparagraph 1(5)(c), the words “taking into consideration the One Health concept”.

The CHAIRMAN said that a revised version of the draft resolution, incorporating the proposed amendments, would be circulated later for consideration at a subsequent meeting.

(For continuation of the discussion and approval of the draft resolution, see the summary record of the twelfth meeting, section 3.)

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

## **ELEVENTH MEETING**

**Monday, 27 May 2013, at 09:10**

**Chairman:** Dr W.T. GWENIGALE (Liberia)

### **1. COMMUNICABLE DISEASES:** Item 16 of the Agenda (continued)

#### **Malaria:** Item 16.3 of the Agenda (Document A66/21)

Dr AL-TAAE (Iraq) said that Iraq had been free of indigenous cases of malaria for over four years. He expressed appreciation for the technical support that had been provided by the Secretariat, in particular concerning capacity-building and the exchange of expertise as part of the joint initiative involving Afghanistan, the Islamic Republic of Iran, Iraq, Pakistan and WHO. Vector surveillance had been recognized as a key element in eliminating malaria; such activities should be integrated into primary health care, using evidence-based family health practices. The target of eliminating malaria should be integrated into health promotion activities, with a focus on health education, communication, social determinants of health, risk factors, and mass gatherings.

Dr LEI Zhenglong (China) said that China was currently implementing the national action plan for malaria elimination 2010–2020. Good progress was being made in diagnosis and treatment, the number of local cases had decreased sharply, and monitoring and evaluation systems had been improved.

His Government was greatly concerned by the artemisinin resistance present in the Greater Mekong subregion of South-East Asia and had adopted several measures to contain it. China had stopped using artemisinin-based monotherapies in 2009, replacing them with artemisinin-based combination therapies. In addition to carrying out cross-border training and monitoring activities, it was paying close attention to manufacturing quality and medicine supply chains.

Malaria control must remain a key priority for global health and development efforts beyond 2015. Relevant organizations and countries should continue providing technical and financial support to African countries with heavy disease burdens, to ensure the sustainability of prevention and control measures and to consolidate the progress that had been made. WHO should also accelerate the prequalification of antimalarial drugs. Furthermore, countries in regions affected by artemisinin resistance should conduct compatibility studies on artemisinin-based combination therapies to reduce the risk of that resistance spreading.

Dr GHEBREHIWET (Eritrea) said that the report should have drawn attention to the tendency for health providers and the public to become complacent once morbidity and mortality rates had declined. It should also have mentioned that malaria would pose a more serious problem if it were to reappear after a long period of successful control, since people would have lost their immunity, and the number of people who had never had malaria would have increased. The report should also have highlighted the need for strategies to combat infection in men since, despite the fact that they were less vulnerable to malaria than children and pregnant women, men who contracted malaria could have a detrimental effect on household economies and poverty alleviation, and could infect others in the community.



Ms BENNETT (Australia) welcomed the Secretariat's work on a global technical strategy for malaria control and elimination for the period 2016–2025 and the work being done in parallel by the Roll Back Malaria Partnership to renew the Global Malaria Action Plan.

Australia's Prime Minister would be co-chairing the Asia-Pacific Leaders Malaria Alliance, the aim of which was to consolidate the political commitment to malaria control in the Region and to implement priority action with regard to financing and access to medicines. She welcomed the support provided by the Secretariat to countries in the Mekong subregion in their efforts to contain artemisinin resistance, which was a challenge not only for the subregion, but potentially for global health. Australia had pledged 5 million Australian dollars to support WHO's emergency response in that field.

Dr COOMBS (Jamaica) said that, after being declared malaria-free in 1965, Jamaica had witnessed a reintroduction of the disease in 2006, which set in motion a national emergency response, followed by an intensive prevention and control programme. Jamaica was recertified as malaria-free in 2012 but it continued to maintain a strong surveillance and vector control programme. Various factors, including inadequate resources, antimalarial drug resistance, vector resurgence, and political and social resistance, threatened to undermine the progress made to date, but that challenge could be met through increased vector control, use of artemisinin-based combination therapies, training, better diagnostic, treatment and surveillance efforts, and political alliances.

Dr FORSTER (Namibia) welcomed the 2012 global plan for insecticide resistance management in malaria vectors but would appreciate more information on progress in the development of new insecticides. Namibia regarded DDT as a key component of elimination efforts across southern Africa and would continue to use it for indoor residual spraying, provided that it was applied under careful, safe and quality-assured conditions by well trained and supervised teams.

The move from malaria control to malaria elimination implied considerable additional costs owing to the broader scope and intensity of the initiative and, to that end, substantial contributions to the fourth replenishment of the Global Fund to Fight AIDS, Tuberculosis and Malaria were needed. Malaria must also remain high on the post-2015 global health and development agenda. His country had significantly increased its national budget allocation for health, including malaria, but without external support, those resources would not be sufficient.

Professor SHIRALIYEV (Azerbaijan) expressed satisfaction that US\$ 1800 million was currently allocated to the fight against malaria. Nevertheless, it was unrealistic to expect a three-fold increase in funding, so it would be necessary to step up the measures against malaria that were already in place, use existing resources rationally and efficiently, adopt innovative approaches to national epidemic surveillance, and implement strategies to combat malaria at various stages of its development.

The tasks assigned to the health sector, government bodies and voluntary associations should be set out clearly, but goals could only be achieved by fully mobilizing efforts and resources, defining priorities, and above all, through political will. Acting on those principles, Azerbaijan had made significant progress in fighting malaria and indeed had almost eliminated it. The Millennium Development Goal on the elimination of malaria in developing countries could be attained by improved interregional coordination and by building stronger partnerships between countries, international organizations and donors.

Dr ANUTTARASAKDI RATCHATATAT (Thailand) said that the emergence of artemisinin resistance in border zones was a major challenge and called for strengthening of cross-border coordination and surveillance systems. In that regard, he asked the Secretariat to organize a forum where participants could share good practices in the implementation of the "T3: Test Treat Track" initiative in countries endemic for the disease.

In many low- and middle-income countries, diagnostics, essential medicines and prevention and control instruments were unaffordable owing to market monopolies, inadequate supply, or poor

management of stockpiles. WHO and other development partners must ensure the supply of low-cost fixed-dose artemisinin-based combination therapies of good quality, sold on the open market, before requesting Member States to stop marketing artemisinin-based monotherapies.

An overall lack of technical expertise and human resources was one reason for the slow implementation of the Global Malaria Action Plan. The Secretariat must continue providing Member States with technical guidance and expertise, and support them in training human resources in malaria prevention and control. Properly functioning health systems, especially at the primary health care level, were fundamental to malaria prevention and control.

Dr SMIRNOVA (Russian Federation) said that, despite increased funding for measures to combat malaria, there was still a substantial shortfall, which might put future progress at risk. Surveillance systems in a number of countries in which malaria was endemic were failing to show the actual disease burden and were in need of improvement, while preventive chemotherapy was still being used far too infrequently to cure children and pregnant women.

The Russian Federation welcomed WHO's efforts to meet those challenges by drawing up new strategies and guidelines, such as the global plan for insecticide resistance management in malaria vectors. The Organization's reviews of national malaria prevention and control programmes were important to countries endemic for malaria. A broad range of international and regional training courses on malaria provided by the Secretariat had been helping administrators to plan and manage measures to control the disease. The Russian Federation had made substantial contributions to international initiatives, including by providing advice and practical support to countries with malaria control programmes and by training managers in countries of the Commonwealth of Independent States and the African Region.

Dr BLOKLAND (Suriname) said that his country had surpassed the Millennium Development Goal target for malaria and was now on the way to eliminating the disease entirely. However, in the Guiana Shield region, malaria was principally transmitted by mobile populations that crossed borders frequently, and strong cross-border collaboration was therefore needed. According to recent studies, *Plasmodium falciparum* malaria in Suriname was 28% less susceptible to artemisinin. Effective diagnostic, therapeutic and preventive measures were therefore urgently needed in the region, and he called on international partners to provide support in that regard. In particular, he urged the Secretariat to continue supporting the WHO office in Suriname in its efforts to prevent the reintroduction of malaria and to step up its support for early diagnosis and treatment programmes for at-risk populations and for the recently established Caribbean Epidemiology Centre.

Mr ELMARDI (Sudan) expressed appreciation for the efforts made by the WHO Global Malaria Programme to establish the sorely needed Malaria Policy Advisory Committee, which counted Sudan's Minister of Health among its members. Sudan had made significant progress in malaria control and prevention by intensifying the action recommended by WHO, but it still faced several challenges, including parasitic resistance to insecticides. He endorsed WHO's effort to develop a global technical strategy for malaria control and elimination for the period 2016–2025, which would provide much-needed support to Member States as they continued to face that challenge.

Dr KAFA (Solomon Islands) said that the annual parasite incidence in his country had decreased four-fold in the previous decade, thanks to support from WHO and donor partners. The national malaria action plan was focused on scaling up control activities in areas of high endemicity and on implementing two pilot elimination programmes. Joint leadership by the provincial government, traditional chiefs and faith-based organizations, together with community involvement, had played an important role in reducing the malaria incidence rate to 0.1 cases per 1000 inhabitants in Isabel province. He urged the Secretariat to continue providing support to his country to ensure that its gains were not lost; in particular WHO should focus on strengthening health systems, empowering communities and bolstering social structures. His Government fully supported integrated community

case management of childhood illnesses, which gave community health workers the opportunity to diagnose and treat malaria, pneumonia and diarrhoea. Malaria control must remain a key priority for global health and development efforts beyond 2015, and WHO should maintain its leadership role in that regard.

Dr LOUME (Senegal) said that Senegal had integrated pneumonia and diarrhoea into its strategy for home-based management of malaria, which had been recently evaluated by WHO. Since 2009, more than 100 health professionals had completed malaria training courses to acquire the skills needed to manage the national malaria programme. With regard to vector control, Senegal had obtained conclusive results in areas where indoor residual spraying had been tested, and it would be pursuing that experience. It was important for neighbouring countries to develop joint malaria control strategies, to ensure that their efforts were coordinated.

Dr WAYESA (Ethiopia) said that according to the *World malaria report 2012*, 25 of the 99 countries with continuing malaria transmission were classified as being in the phases of pre-elimination, elimination or prevention of reintroduction. Unfortunately, African countries with high malaria burdens did not appear on that list of 25 countries, and they deserved more attention. He urged Member States to advocate for and contribute to the Global Fund to Fight AIDS, Malaria and Tuberculosis, in order to build on the progress made.

Dr BENSON (South Africa) commended the collective efforts that had enabled 50 countries to be close to reducing malaria incidence by 75%, in line with the Roll Back Malaria target. South Africa had reduced mortality by 89% and morbidity by 84% between 2000 and 2012. Yet it had not been classified in the *World malaria report 2012* as having entered the pre-elimination stage and, in that regard, he requested more information about the criteria to be met for inclusion in that category. He was concerned by the substantial funding shortfall predicted to occur annually up to 2020, and called for international and domestic partners to ensure that more creative and sustainable ways of raising additional funding were identified. He was also concerned about reports of mosquito resistance to insecticides and by renewed calls to phase out the use of DDT, even though it had proven to be effective for malaria vector control. He called on the Secretariat to continue its support for strengthening cross-border malaria initiatives in Africa. The global technical strategy for malaria control and elimination to be prepared by the Malaria Policy Advisory Committee would help to guide the progress of South Africa's own national malaria control strategy.

Dr ISSOUFOU (Niger), speaking on behalf of the Member States of the African Region, said that despite worldwide efforts to combat malaria, which had been successful in reducing the mortality rate, disease transmission persisted in 99 countries and territories. Furthermore, despite a substantial increase in funding in recent years, funding shortages were having a negative impact on supplies of antimalarial drugs and other materials, and on plans to broaden the scope of interventions, all of which could lead to a resurgence of malaria. The Member States of the Region were committed to preserving the gains made and achieving the global targets set, and would do so by implementing the Secretariat's proposals, including the global plan for insecticide resistance management in malaria vectors; the recommendation on seasonal malaria chemoprevention for control of *P. falciparum* malaria; the programme to support the expansion of integrated community case management of childhood illnesses; and development of new co-financing and technology transfer mechanisms and improved surveillance systems.

Dr NTAKARUTIMANA (Burundi) said that malaria continued to be a major public health problem in his country and a leading cause of morbidity and mortality. Burundi supported all the strategies that had been proposed for controlling the disease, particularly the use of indoor residual spraying, which had been tested with excellent results in one of his country's provinces. He appealed to WHO and international and local partners to increase funding for implementing that strategy.

Dr JANAIRO (Philippines) said that under its national malaria programme, his country had over the past eight years reduced the number of malaria cases by 79% and the number of deaths by 92%, thereby achieving the global targets that had been set. To preserve those gains, support from WHO and international partners was needed, in particular, to help the Philippines establish strong surveillance systems; ensure the diagnostic, treatment and vector control capabilities of all the country's regions by guaranteeing the supply of malaria commodities; carry out and sustain social mobilization activities; and foster strong coordination among government units at all levels. Funding for the national malaria programme would be increased by revenue from the country's new tax law, but continuing international support was still needed, since funding under the Global Fund to Fight AIDS, Tuberculosis and Malaria was ensured only until 2014.

Mr KLEIMAN (Brazil) said that combating malaria was a priority in Brazil. In recent years, the number of deaths had been reduced by 70%, and morbidity had also declined. That success was due to the decentralization of prevention and control activities to local and provincial governments, an improvement in patient treatment and care, and investment in and training of human resources. However, the challenge remained significant, particularly in the Amazon region. His country had been working on research into and development of vaccines and medications, for example, in cooperation with the Drugs for Neglected Diseases initiative. It was also endeavouring to cooperate in a more integrated manner with other countries in the Amazon region, particularly those on its border. The combat against malaria must remain on the post-2015 agenda, so that countries that had not yet achieved the targets would continue to receive international support, including from WHO.

Dr AFZAL (Pakistan) said that malaria had become one of the major causes of morbidity in Pakistan and controlling it was a priority. The Government had revised its malaria policy by including in it a strategy for the province of Punjab, as it moved from control to pre-elimination, and by setting targets for intensified control activities in high-burden areas along the western border. Pakistan had introduced artemisinin-based combination therapy as a first-line therapy, banned monotherapy, strengthened surveillance and developed national guidelines and a training manual, and would be working to strengthen its malaria programme even further.

Mr OVIEDO (Costa Rica) said that Costa Rica had been among the countries classified by the *World malaria report 2012* as being in the pre-elimination phase. It was cooperating with other countries in the region on a joint initiative to eliminate malaria in Central America and Hispaniola by 2025, in partnership with the Global Fund to Fight AIDS, Tuberculosis and Malaria (which planned to contribute US\$ 10 million to it), PAHO and the Bill & Melinda Gates Foundation. The final proposal for the initiative would be submitted to the Global Fund at the meeting of the Council of Ministers of Health of Central America in June 2013. He urged Member States to use an integrated approach to the prevention and control of malaria.

Ms RIGHETTI (Switzerland) said that an increase in and better use of available resources, long-term commitment from all Member States, and coordination of the stakeholders involved were essential if the fight against malaria were to be successful. Malaria control should be part of the strategy to strengthen health systems at the national level. She endorsed the appeal from affected countries for greater funding, but co-financing initiatives must be part of countries' overall health funding strategies. Community participation in malaria control programmes was vital to ensuring that prevention and treatment methods were well known, applied in an effective manner and accessible to all. Universal health coverage must include strategies for combating malaria at the community level. Better surveillance and information systems in malaria-endemic countries were needed, as were innovative approaches to vector control, monitoring of drug resistance, early diagnosis and treatment, and research relating to vector control. Alternative vector control methods should be developed so that the use of DDT could be gradually eliminated.

Mr KOLKER (United States of America) welcomed the information that malaria mortality had decreased by 25% worldwide and by 33% in the African Region between 2000 and 2010. His Government endorsed the efforts of the WHO Global Malaria Programme to strengthen its policy-making process and was concerned by the forecasted funding shortfall; it therefore encouraged all partners to renew their commitment to funding malaria prevention programmes. It was for that reason that the United States of America had proposed that malaria should be included on the agenda as a technical item.

Emerging insecticide and antimalarial drug resistance threatened the success that had been achieved. More than one third of antimalarial drugs tested in surveillance programmes in sub-Saharan Africa and South-East Asia were counterfeit or substandard. Compromised medicines could lead to resistant strains of the parasite, making the disease more difficult to treat, even with quality medicines. The United States of America was in favour of public–private partnerships for testing and identifying counterfeit or substandard antimalarial medicines, including falsified products. His country would continue to support efforts to identify and control antimalarial drug resistance and effectively manage insecticide resistance, and urged all Member States to promote the deployment of proven, effective interventions.

Dr SON Hyun-jin (Republic of Korea) said that her country aimed to reduce the incidence of malaria cases to less than one per 100 000 by 2015 and to eliminate the disease entirely by 2017, through intensive patient management focused on early detection and treatment. Only *Plasmodium vivax* malaria was prevalent in the Republic of Korea, which meant that drug resistance was not a problem. However, artemisinin resistance had been detected in neighbouring countries, and her country would be joining the cross-border efforts to contain it.

Mrs KHUMALO (Swaziland) said that malaria remained a serious public health issue and had been rightly placed on the agenda as a technical item. Donor contributions to the Global Fund to Fight AIDS, Tuberculosis and Malaria were making a difference in the lives of people in sub-Saharan Africa and replenishment of the Fund was of vital importance. It was encouraging that some countries in the African Region, including her own, were on track to meet the targets that had been set for malaria control. Nevertheless, greater South–South and cross-border cooperation was needed to achieve sustainable progress in Africa. Malaria prevention and control should remain a key priority for global health and development beyond 2015.

Dr LANE (United Kingdom of Great Britain and Northern Ireland) supported the decision to include malaria as a full technical item on the agenda. His Government welcomed the high-level political commitment to combating malaria in high-burden countries, and it intended to provide up to £500 million to help halve malaria deaths in at least 10 of those countries by 2015.

Institutions and companies in the United Kingdom of Great Britain and Northern Ireland were at the forefront of research and development to generate new tools and products for combating malaria. He welcomed the preparation of a global technical strategy for malaria control and elimination for the period 2016–2025; it should be based on the principle of evidence-based malaria programming and would help to consolidate the gains of the previous decade and accelerate progress towards the health goals on the post-2015 development agenda.

Mr ROMERO PUENTES (Cuba) said that, since eliminating malaria in 1967, Cuba had been developing a strong epidemiological and entomological monitoring system at the primary level and gaining experience in the development of human resources and environmentally friendly products, with a view to sustaining its achievements. Setting up a vector control mechanism at the primary health care level had made it possible to localize and identify malaria vectors and treat them with biolarvicides which, in addition to being effective, were not harmful to the environment and did not generate resistance in other vectors. His country was sharing its experience by transferring its

production technology and work methods to other countries and cooperating with them in general on malaria control programmes.

Mrs OGU (Nigeria) said that long-lasting insecticide-treated nets alone could not eliminate malaria. Multiple vector control strategies were needed, including indoor residual spraying, the use of larvicides, cross-border surveillance and accelerated technology transfer to build local capacities for manufacturing antimalarial products.

Mr MUKALENGE (Democratic Republic of the Congo) said that despite having the second-highest malaria mortality rate in the world, his country had nevertheless made significant progress in combating the disease in recent years, particularly through mass distribution of long-lasting insecticide-treated nets and by supplying health centres with artemisinin-based combination therapies, rapid diagnostic testing kits and sulfadoxine-pyrimethamine. Access to and use of those services remained a challenge, as did the logistics of ensuring reliable services in a country as large as his own. In the previous two years, there had been a recrudescence of malaria in districts with no prior history of cases on that scale, with a disproportionate number of young malnourished children falling ill. To make matters worse, unreliable test results were leading the health workers involved to make inappropriate treatment decisions, with sometimes disastrous consequences. He therefore wished to underline the importance of improving malaria surveillance systems in the 17 most affected countries and of providing support to them in establishing effective laboratory networks.

Ms NGARI (Kenya) said that, on the recommendation of her country's Ministry of Health, carbamates would be used for indoor residual spraying in areas with perennial malaria transmission in the 2013–2014 spraying cycle. That important policy change had been made as a result of recent findings demonstrating high-level resistance to pyrethroid-based insecticides, as opposed to organophosphate and carbamate-based insecticides. Kenya had also completed a programme of mass distribution of long-lasting insecticide-treated nets to all target areas, and rapid diagnostic test kits were being used to strengthen malaria diagnosis and management.

Ms DÁVILA CHÁVEZ (Mexico) said that Mexico had achieved good results in combating malaria but it remained a health priority in some areas of the country. Since 2004, Mexico had been using targeted approaches in order to obtain WHO malaria-free certification, especially for tourist centres and industrial development zones. Her country would be glad to share its national experiences with any country that requested it.

Mr SAMO (Federated States of Micronesia) said that his delegation had been in favour of including malaria as a technical item on the agenda. His Government appreciated the mosquito nets provided by WHO and global partners for preventing other mosquito-borne diseases.

Dr MALEFHO (Botswana) said that, through its national malaria programme, Botswana had dramatically reduced unconfirmed and confirmed malaria incidence, while deaths attributed to malaria had shown a 91.4% decrease between 2000 and 2012, leading the Government to predict that it would be able to eliminate malaria by the target date of 2015. Several initiatives undertaken by the Ministry of Health had contributed to the downward trend, including strengthening the policy-making process; providing evidence-based technical guidance; monitoring trends in malaria control and elimination; strengthening human resources; promoting technology transfer; combating insecticide resistance, and mitigating shortages in the supply of artemisinin-based combination therapy.

Challenges nevertheless remained that had the potential to reverse the gains made, the most serious being the limited resources available globally for malaria prevention and control.

Dr AL LAMKI (Oman) said that efforts to build on the tremendous progress achieved in implementing the global strategy for malaria control could be jeopardized by inadequate funding in countries that were endemic for malaria, particularly in view of growing antimalarial drug resistance. It was vital to combat malaria in those countries, in order to reduce their disease burden; that in turn would have a positive impact on the disease burden of countries with imported malaria, including by minimizing the risk of domestic transmission. Thanks to a robust malaria control programme, domestic transmission had been eliminated in Oman, which nonetheless faced the major challenge of monitoring incoming cases from nearby countries where malaria was endemic.

Dr DAKULALA (Papua New Guinea) said that although malaria was one of the most important public health problems in Papua New Guinea, morbidity, mortality and parasite prevalence had all declined considerably between 2000 and 2011. In addition, malaria was no longer one of the top three causes of hospital admission for children, owing to the widespread use of insecticide-treated bed nets, of which 5.1 million had been distributed free of charge in the previous 10 years. Artemisinin-based combination therapy had been introduced as the first-line treatment in 2009. Rapid diagnostic tests were being introduced in all health facilities, and testing and treatment coverage was expanding through community-based case management. Under the country's policy of free primary health care, efforts would be made to increase equity and access to diagnosis and treatment.

Strong public-private partnerships and collaboration with WHO, research institutions and nongovernmental organizations had enabled the country to expand its malaria programme, and malaria control was included in its national health plan 2011–2020 as a priority objective. Nevertheless, diagnostic capacity and laboratory quality assurance remained key challenges, and the supply of artemisinin monotherapies by the private sector meant that staff did not always comply with treatment guidelines. Furthermore, the quality of the malaria programme and its potential for expansion were likely to be jeopardized by the health workforce crisis in his country, which must be tackled immediately. The progress that had been made was a result of international efforts to combat malaria, and he therefore supported the call for sustained financial and technical support.

Mr EMANUELE (Ecuador) said that his country's firm political commitment to combating malaria had led to significant improvements in diagnosis, treatment and follow-up of cases, thus eliminating local transmission. In November 2012, PAHO had named Ecuador a "champion in the fight against malaria", in recognition of the work done by the country's national service for control of vector-borne diseases, which had reduced the incidence of malaria by 70% in the previous two years. It was important to promote and disseminate good practices, since that would foster international cooperation and help other countries to achieve similar results. Despite the significant progress that had been made towards attaining the Millennium Development Goals, the control of communicable diseases like malaria must continue to rank high on the post-2015 development agenda, to ensure the sustainability of what had already been achieved.

Dr WIDIYARTI (Indonesia) said that global and national investments in malaria control had yielded significant results in decreasing the disease burden in Indonesia, and districts where malaria had previously been endemic were moving towards elimination of the disease.

The country's health system was being strengthened using an integrated health services approach that had resulted in an increase in coverage with long-lasting insecticidal nets, a decline in the annual parasite index and improved access to treatment. The Government was committed to increasing community access through campaigns to distribute more long-lasting insecticidal nets, and establish village malaria posts and mobile clinics in remote areas. Artemisinin resistance was being dealt with by efforts to promote a standardized treatment regimen, in conjunction with professional organizations. Continued technical support from WHO, other international organizations and development partners would be welcome.

Mr Chin-Shui SHIH (Chinese Taipei) said that malaria had been eradicated in Chinese Taipei in 1965, as a result of a control and eradication programme launched in 1945. Chinese Taipei was currently in a maintenance phase of sustained control and was malaria-free. Chinese Taipei strongly supported the WHO Global Malaria Programme's new initiative "T3: Test Treat Track". Chinese Taipei had been collaborating with WHO and other partners on malaria prevention and control in countries endemic for the disease and welcomed the opportunity to do so in the future.

Dr NAKATANI (Assistant Director-General), said that the world was, overall, on track to reach the Millennium Development Goal target on malaria. However, an estimated 660 000 lives were still lost to malaria each year, mostly in sub-Saharan Africa, a figure almost double that attributed to maternal deaths. Drug and insecticide resistance still presented considerable challenges, although existing tools had generally been effective in many countries. Unnecessary deaths could be avoided through further expansion of evidence-based interventions, such as the use of long-lasting insecticidal nets, indoor residual sprays, diagnostic tests and artemisinin-based combination therapies for uncomplicated cases.

Delegates had expressed their views on four broad areas: the post-Millennium Development Goal strategy; artemisinin resistance; insecticide resistance; and funding. Many delegates had expressed full support for the development of a post-2015 global technical strategy for malaria control and elimination, to be overseen by the Malaria Policy Advisory Committee. The new strategy would be based on a comprehensive evidence review and regional consultations, and would be submitted for consideration to the Sixty-eighth World Health Assembly in May 2015. The strategy would cover the period 2016–2025 and provide a solid technical foundation for the second version of the Roll Back Malaria Partnership's Global Malaria Action Plan.

Member States had referred to artemisinin resistance and the need for closer cross-border collaboration, including strengthened surveillance, since maintaining the efficacy of artemisinin-based combination therapy was critical for malaria control. Resistance to artemisinins had first been detected in the border area between Thailand and Cambodia and had then spread to the Greater Mekong area. On World Malaria Day 2013, WHO had introduced its emergency response to artemisinin resistance in the Greater Mekong subregion, which included a regional framework for action for 2013–2015. The framework would be assessed from the perspective of the countries affected. The data on weakened efficacy of artemisinin-based combination therapy had been reviewed by the Malaria Policy Advisory Committee which, following further study, would be issuing recommendations in that regard.

Insecticide resistance remained a major threat to malaria control efforts, and in response WHO had launched a global plan for insecticide resistance management in 2012. The plan called for increased monitoring efforts and the development of a country-specific response, as well as for the intensification of research to identify new insecticides and new approaches to vector control.

In respect of funding, Member States had acknowledged the importance of the Global Fund to Fight AIDS, Tuberculosis and Malaria, since it represented about 60% of international resources. Nevertheless, it was satisfying to note that domestic resources were increasing. He called on all partners to work together to ensure funding for malaria control until the disease had been fully eliminated.

**The Committee noted the report.**



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

**Draft comprehensive global monitoring framework and targets for the prevention and control of noncommunicable diseases:** Item 13.1 of the Agenda (Documents A66/8 and A66/8 Add.1) (continued from the first meeting, section 3)

**Draft action plan for the prevention and control of noncommunicable diseases 2013–2020:** Item 13.2 of the Agenda (Documents A66/9 and A66/9 Corr.1) (continued from the first meeting, section 3)

The CHAIRMAN drew attention to a revised draft resolution that had been prepared by a drafting group set up at the Committee's first meeting. The revised draft resolution, proposed by the delegations of Australia, Bahrain, Barbados, Belgium, Brazil, Canada, China, Colombia, Costa Rica, Côte d'Ivoire, Denmark, Djibouti, Finland, Ghana, Iraq, Libya, Malaysia, Mexico, Monaco, Mongolia, Nigeria, Norway, Pakistan, Panama, Russian Federation, Singapore, South Africa, Spain, Suriname, Sweden, Switzerland, Thailand, United Kingdom of Great Britain and Northern Ireland, United Republic of Tanzania, United States of America, Uruguay, and Zimbabwe, read:

The Sixty-sixth World Health Assembly,

PP1 Having considered the reports by the Secretariat to the Sixty-sixth World Health Assembly on noncommunicable diseases;<sup>1</sup>

PP2 Recalling the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases,<sup>2</sup> which acknowledges that the global burden and threat of noncommunicable diseases constitutes one of the major challenges for development in the twenty-first century and which also requests the development of a comprehensive global monitoring framework, including a set of indicators, calls for recommendations on a set of voluntary global targets, and requests options for strengthening and facilitating multisectoral action for the prevention and control of noncommunicable diseases through effective partnership;

PP3 Welcoming the outcome document of the United Nations Conference on Sustainable Development (Rio de Janeiro, 20–22 June 2012), entitled "The future we want",<sup>3</sup> which commits to strengthen health systems towards the provision of equitable, universal health coverage and promote affordable access to prevention, treatment, care and support related to noncommunicable diseases, especially cancer, cardiovascular diseases, chronic respiratory diseases and diabetes, and commits to establish or strengthen multisectoral national policies for the prevention and control of noncommunicable diseases;

PP4 Taking note with appreciation of all the regional initiatives undertaken on the prevention and control of noncommunicable diseases, including the Declaration of the Heads of State and Government of the Caribbean Community entitled "Uniting to stop the epidemic of chronic noncommunicable diseases", adopted in September 2007, the Libreville Declaration on Health and Environment in Africa, adopted in August 2008, the statement of the Commonwealth Heads of Government on action to combat noncommunicable diseases, adopted in November 2009, the declaration of commitment of the Fifth Summit of the Americas, adopted in June 2009, the Parma Declaration on Environment and Health, adopted by the Member States of the WHO European Region in March 2010, the Dubai Declaration on Diabetes and Chronic Noncommunicable Diseases in the Middle East and Northern Africa Region, adopted in December 2010, the European Charter on Counteracting Obesity, adopted in

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<sup>1</sup> Documents A66/8 and A66/9.

<sup>2</sup> United Nations General Assembly resolution 66/2.

<sup>3</sup> United Nations General Assembly resolution 66/288.

November 2006, the Aruba Call for Action on Obesity of June 2011, and the Honiara Communique on addressing noncommunicable disease challenges in the Pacific region, adopted in July 2011;

PP5 Acknowledging the Moscow Declaration adopted by the First Global Ministerial Conference on Healthy Lifestyles and Noncommunicable Disease Control (Moscow, 28–29 April 2011), endorsed by the Sixty-fourth World Health Assembly (resolution WHA64.11), which requests the Director-General to develop, together with relevant United Nations agencies and entities, an implementation and follow-up plan for the outcomes of the Conference and the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases (New York, 19–20 September 2011) for submission to the Sixty-sixth World Health Assembly;

PP6 Acknowledging also the Rio Political Declaration on Social Determinants of Health adopted by the World Conference on Social Determinants of Health (Rio de Janeiro, 19–21 October 2011), endorsed by the Sixty-fifth World Health Assembly in resolution WHA65.8, which recognizes that health equity is a shared responsibility and requires the engagement of all sectors of government, all segments of society, and all members of the international community, in an “all-for-equity” and “health-for-all” global action;

PP7 Recalling resolution EB130.R7, which requests the Director-General to develop, in a consultative manner, a WHO global action plan for the prevention and control of noncommunicable diseases for 2013–2020 and decision WHA65(8)<sup>1</sup> and its historic decision to adopt a global target of a 25% reduction in premature mortality from noncommunicable diseases by 2025;

PP8 Reaffirming WHO’s leading role as the primary specialized agency for health, including its roles and functions with regard to health policy in accordance with its mandate, and reaffirming its leadership and coordination role in promoting and monitoring global action against noncommunicable diseases in relation to the work of other relevant United Nations agencies, development banks and other regional and international organizations in addressing noncommunicable diseases in a coordinated manner;

PP8*bis* Recognizing the primary role and responsibility of governments in responding to the challenges of noncommunicable diseases;

PP8*ter* Recognizing also the important role of the international community and international cooperation in assisting Member States, particularly developing countries, in complementing national efforts to generate an effective response to noncommunicable diseases;

PP9 Stressing the importance of North–South, South–South and triangular cooperation in the prevention and control of noncommunicable diseases, to promote at the national, regional and international levels an enabling environment to facilitate healthy lifestyles and choices, bearing in mind that South–South cooperation is not a substitute for, but rather a complement to, North–South cooperation;

PP10 Noting that noncommunicable diseases are often associated with mental disorders and other conditions and that mental disorders often coexist with other medical and social factors as noted in resolution WHA65.4 and that, therefore, the implementation of the WHO global action plan for the prevention and control of noncommunicable diseases 2013–2020 is expected to be implemented coherently and in close coordination with the WHO global mental health action plan 2013–2020 and other WHO action plans at all levels;

PP11 Welcoming the overarching principles and approaches of the WHO global action plan for the prevention and control of noncommunicable diseases 2013–2020,<sup>2</sup> and calling for their application in the implementation of all actions to prevent and control noncommunicable diseases;

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<sup>1</sup> Decision WHA65(8), WHA65/2012/REC/1.

<sup>2</sup> As detailed in paragraph 18 of the action plan.

PP12 Recognizing that the United Nations Secretary-General, in collaboration with Member States, WHO and relevant funds, programmes and specialized agencies of the United Nations system is to present to the United Nations General Assembly at its sixty-eighth session a report on the progress achieved in realizing the commitments made in the Political Declaration of the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases, in preparation for a comprehensive review and assessment in 2014 of the progress achieved in the prevention and control of noncommunicable diseases,

DECIDES:

OP1 to endorse the WHO global action plan for the prevention and control of noncommunicable diseases 2013–2020;<sup>1</sup>

OP2 to adopt the comprehensive global monitoring framework for the prevention and control of noncommunicable diseases, including the set of 25 indicators capable of application across regional and country settings to monitor trends and to assess progress made in the implementation of national strategies and plans on noncommunicable diseases, as detailed in Appendix 1 of document A66/8;

OP3 to adopt the set of nine voluntary global targets for achievement by 2025 for the prevention and control of noncommunicable diseases, as detailed in Appendix 2 of document A66/8, noting that the target related to a 25% relative reduction in overall mortality from cardiovascular diseases, cancer, diabetes or chronic respiratory diseases concerns premature mortality from noncommunicable diseases between ages 30 and 70, in accordance with the corresponding indicator;

OP4 URGES Member States:<sup>2</sup>

(1) to continue to implement the Political Declaration of the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases, strengthening national efforts to address the burden of noncommunicable diseases, and continuing to implement the Moscow Declaration;

(2) to implement, as appropriate, the action plan and to take the necessary steps to meet the objectives contained therein;

(2bis) to enhance the capacity, mechanisms and mandates, as appropriate, of relevant authorities in facilitating and ensuring action across government sectors;

(3) to accelerate implementation by Parties of the WHO Framework Convention on Tobacco Control, including through adopted technical guidelines; other countries to consider acceding to the Convention, as well as to give high priority to the implementation of the Global Strategy on Diet, Physical Activity and Health endorsed in resolution WHA57.17, the global strategy to reduce the harmful use of alcohol endorsed in resolution WHA63.13, and the recommendations on the marketing of foods and non-alcoholic beverages to children endorsed in resolution WHA63.14, as being integral to making progress towards the voluntary global targets and realizing the commitments made in the Political Declaration of the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases;

(4) to promote, establish, support and strengthen engagement or collaborative partnerships, as appropriate, including with non-health and non-State actors, such as civil society and the private sector, at the national, subnational and/or local levels for the prevention and control of noncommunicable diseases, according to country circumstances, with a broad multisectoral approach, while safeguarding public health

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<sup>1</sup> See WHA66/2013/REC/1, Annex 4.

<sup>2</sup> And, where applicable, regional economic integration organizations.

interests from undue influence by any form of real, perceived or potential conflict of interest;

(5) to consider the development of national noncommunicable disease monitoring frameworks, with targets and indicators based on national situations, taking into consideration the comprehensive global monitoring framework, including the 25 indicators and a set of nine voluntary global targets, building on guidance provided by WHO, to focus on efforts to prevent and address the impacts of noncommunicable diseases, to support scaling up effective noncommunicable disease actions and policies, including technical and financial aspects, and to assess the progress made in the prevention and control of noncommunicable diseases and their risk factors and determinants;

(6) to establish and strengthen, as appropriate, a national surveillance and monitoring system to enable reporting including against the 25 indicators of the comprehensive global monitoring framework, the nine voluntary global targets, and any additional regional or national targets and indicators for noncommunicable diseases;

(7) to recommend that the United Nations Economic and Social Council considers the proposal for a United Nations Task Force on Noncommunicable Diseases, which would coordinate the activities of the United Nations organizations in the implementation of the WHO global noncommunicable disease action plan before the end of 2013, which would be convened and led by WHO and report to ECOSOC, incorporating the work of the United Nations Ad Hoc Interagency Task Force on Tobacco Control while ensuring that tobacco control continues to be duly addressed and prioritized in the new task force mandate;

(8) to support the work of the Secretariat to prevent and control noncommunicable diseases, in particular through funding relevant work included in the programme budgets;

(9) to continue to explore the provision of adequate, predictable and sustained resources, through domestic, bilateral, regional and multilateral channels, including traditional and voluntary innovative financing mechanisms and to increase, as appropriate, resources for national programmes for prevention and control of noncommunicable diseases;

#### OP5 REQUESTS the Director-General:

(1) to submit the detailed and disaggregated information on resource requirements necessary to implement the actions for the Secretariat included in the global action plan for the prevention and control of noncommunicable diseases 2013–2020, including information on the financial implications of the establishment of a global coordination mechanism for the prevention and control of noncommunicable diseases, to the first financing dialogue convened by the Director-General and facilitated by the Chairman of the Programme, Budget and Administration Committee of the Executive Board, on the financing of the Programme budget 2014–2015, with a view to ensuring that all partners have clear information on the specific funding needs, available resources and funding shortfalls of the actions for the Secretariat included in the action plan at the project or activity level;

(2) to develop draft terms of reference for a global coordination mechanism, as outlined in paragraphs 14–15 of the WHO global action plan for the prevention and control of noncommunicable diseases 2013–2020, aimed at facilitating engagement among Member States, United Nations funds, programmes and agencies, and other international partners and non-State actors, while safeguarding WHO and public health from undue influence by any form of real, perceived or potential conflicts of interest, without pre-empting the results of ongoing WHO discussions on engagement with non-State actors;

(3) to develop the draft terms of reference referred to in paragraph 5.2 through a formal Member States'<sup>1</sup> meeting in November 2013, preceded by consultations with:

- (i) Member States,<sup>1</sup> including through regional committees;
- (ii) United Nations agencies, funds and programmes and other relevant intergovernmental organizations;
- (iii) nongovernmental organizations and private sector entities, as appropriate, and other relevant stakeholders;

and to be submitted, through the Executive Board, to the Sixty-seventh World Health Assembly for approval;

(4) to develop, in consultation with Member States and other relevant partners, a limited set of action plan indicators to inform reporting on progress, which build on the work under way at regional and country levels, are based on feasibility, current availability of data, best available knowledge and evidence, are capable of application across the six objectives of the action plan, and minimize the reporting burden on Member States to assess progress made in 2016, 2018 and 2021 in the implementation of policy options for Member States, recommended actions for international partners, and actions for the Secretariat included in the action plan, and to submit the draft set of action plan indicators, through the Executive Board, to the Sixty-seventh World Health Assembly for approval;

(5) to work together with other United Nations funds, programmes and agencies to conclude the work, before the end of October 2013, on a division of tasks and responsibilities for United Nations funds, programmes and agencies and other international organizations;

(6) to provide technical support to Member States, as required, to support the implementation of the WHO global action plan for the prevention and control of noncommunicable diseases 2013–2020;

(7) to provide technical support to Member States, as required, to establish or strengthen national surveillance and monitoring systems for noncommunicable diseases to support reporting under the global monitoring framework for noncommunicable diseases;

(8) to provide technical support to Member States, as required, to engage/cooperate with non-health government sectors and, in accordance with principles for engagement, with non-State actors,<sup>2</sup> in the prevention and control of noncommunicable diseases;

(9) to submit reports on progress made in implementing the action plan, through the Executive Board, to the Health Assembly in 2016, 2018<sup>3</sup> and 2021,<sup>2</sup> and reports on progress achieved in attaining the nine voluntary global targets in 2016, 2021 and 2026;

(10) to propose an update of Appendix 3 of the WHO global action plan for the prevention and control of noncommunicable diseases 2013–2020, as appropriate, to be considered, through the Executive Board, by the World Health Assembly, in the light of new scientific evidence and to continue to update, as appropriate Appendix 4.

Mr McIFF (United States of America), speaking in his capacity as co-chair of the drafting group established by the Committee at its first meeting, said that the drafting group had been open to all Member States and had held nine meetings. The drafting group had reached consensus on several new tasks to be assigned to the Secretariat, including the provision of technical support to Member States with implementation of the revised global action plan; the development of terms of reference for a

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

<sup>2</sup> Without prejudice to ongoing discussions on WHO engagement with non-State actors.

<sup>3</sup> The progress reports in 2018 and 2021 should include the outcomes of independent evaluation of the implementation of the global action plan conducted in 2017 and 2020.

global coordination mechanism; the development of a limited set of action plan indicators to be used in reporting on progress to the governing bodies; and the updating of a menu of policy options and cost-effective interventions for the prevention and control of noncommunicable diseases.

He wished to highlight several events that had taken place during the meetings of the drafting group. First, the Secretariat had assured Member States that the participation of non-State actors in the proposed global coordination mechanism would be in line with the principles concerning the Organization's engagement with non-State actors, to be considered by the Sixty-seventh World Health Assembly. Secondly, Member States had agreed that the Secretariat would make document A65/7 and United Nations General Assembly document A/67/373 available as background documents during the consultations prior to the formal meeting to complete work on terms of reference for the global coordination mechanism. Thirdly, the delegate of Mongolia had requested the Secretariat to begin work on an instrument relating to the harmful use of alcohol, similar in nature to the Framework Convention on Tobacco Control. However, it had become clear in recent years that, although Member States agreed on the objective of reducing the harmful use of alcohol, not all supported the idea of a convention. The Secretariat could not therefore start work on a convention until a consensus had been reached. Fourthly, the Secretariat had assured Member States that it would pursue its efforts to explore informal collaborative arrangements regarding palliative care and pain management with the United Nations Office on Drugs and Crime and the International Narcotics Control Board. Fifthly, the Secretariat had given its assurances that it would include an update on the progress made in completing the tasks assigned to the Organization in the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases, and in the present draft resolution, in the report of the Director-General of WHO that would serve as input for a comprehensive review and assessment of the prevention and control of noncommunicable diseases, to be conducted by the United Nations General Assembly in 2014.

Dr AHMED ELBASHEER (Sudan), endorsing the draft global action plan and the draft comprehensive global monitoring framework, said that she was pleased that the drafting committee had taken into consideration the reservations expressed by her delegation, so that children were now taken into account in both drafts.

Dr SON Hyun-jin (Republic of Korea) welcomed the draft action plan and the draft monitoring framework. Her country had high expectations for the interim reports that would be issued in 2015 and 2020 and the final report in 2025.

The Republic of Korea, which was currently serving as Chair for the Conference of the Parties to the WHO Framework Convention on Tobacco Control, considered that the Convention had been producing visible and tangible results for which WHO should be credited. It might be possible to envisage a similar initiative in the area of alcohol.

Given the potential for friction between health and commerce, the Secretariat should be encouraged to strengthen dialogue and collaboration with economic organizations such as WTO and WIPO.

Professor MESBAH (Algeria) emphasized the importance that his country attached to access to affordable medicines, particularly in light of the high cost of medicines for noncommunicable diseases. He looked to WHO for support in establishing mechanisms for bulk procurement of medicines and in promoting local production through intercountry cooperation, which was particularly important for countries such as his own with emerging pharmaceutical industries.

Ms DÁVILA CHÁVEZ (Mexico) said that Mexico's national strategy to tackle its serious problem of overweight and obesity and to reduce the preventable and avoidable burden of morbidity, mortality and disability due to noncommunicable diseases was focused on three major areas: health promotion and prevention, effective access to health services, and public policy. That approach was fully in line with the overarching principles of the draft global action plan. To enable Member States

to make realistic commitments, the voluntary global targets set out in the plan should take national conditions into account.

Mr O'BRIEN (Trinidad and Tobago) said that his country wished to sponsor the draft resolution under consideration. The Heads of Government of the countries of the Caribbean Community (CARICOM) had worked very hard to place noncommunicable diseases on the United Nations development agenda and he urged the Secretariat to ensure that the item would continue to have priority on that agenda.

Dr AL-TAAE (Iraq), confirming the agreement that had been reached within the Eastern Mediterranean Region concerning the draft global action plan, said that Iraq's strategic plan for the prevention and control of noncommunicable diseases had been incorporated into its national development plan. All the relevant ministries were working in partnership with the private sector to achieve the goals relating to noncommunicable diseases, and a national committee had been set up to monitor and evaluate progress towards those goals, for which a time limit had been set. The strategic plan had also been incorporated into primary health care and family medicine. Surveillance of noncommunicable and communicable diseases had been linked, and efforts had been made to incorporate noncommunicable diseases into other health strategies to ensure that account was taken of them in programme implementation mechanisms at the district and community levels.

Mr ZITKO (Slovenia) said that noncommunicable diseases and related health inequalities posed a growing challenge for his country. His Government had begun reforming the primary health care system with a view to strengthening prevention, detection and case management of noncommunicable diseases. The draft comprehensive global monitoring framework and the 25 indicators it contained would serve as a guide for national efforts to reduce health inequalities.

Slovenia had spearheaded the efforts to launch the European Partnership on Action Against Cancer and was particularly concerned by diseases attributable to preventable environmental factors, including exposure to chemicals. Resolution WHA63.26 on the improvement of health through sound management of obsolete pesticides and other obsolete chemicals reflected the resolution adopted by the International Conference on Chemicals Management at its first session in February 2006, and implementation of both resolutions was crucial for easing the burden of noncommunicable diseases. He endorsed the recent appeal of the UNEP Governing Council that WHO continue to provide health expertise within the secretariat of the Strategic Approach to International Chemicals Management.

Ms LANGEROCK (Belgium), welcoming the draft global action plan, said that the social determinants of health should be kept in mind when adapting the plan to national realities, in order to reduce inequalities between and within countries as much as possible. Multisectoral action at the global and national levels was essential, and she therefore endorsed the proposed global coordination mechanism. The agreements reached in respect of the draft global action plan and the draft comprehensive global monitoring framework were balanced compromises, and her country was proud to be a sponsor of the draft resolution. The next step in facing the global public health challenge presented by noncommunicable diseases was to implement the measures set out in the action plan.

Ms GÓNGORA TORRES (Colombia) said that the population of Colombia suffered disproportionately from noncommunicable diseases, particularly cardiovascular disease, which was the principal cause of morbidity and mortality. Her Government endorsed the request in the draft resolution that the Director-General develop terms of reference for a global coordination mechanism because, under a "health-in-all-policies" approach (which Colombia supported), as it was important to establish objectively the contributions of "all" to health. The social, economic and environmental aspects of health, as well as the risks of co-morbidity, should be kept in mind during implementation of the global action plan, which should be adapted to the contexts of individual countries.

Ms WISEMAN (Canada) commended all those who had been involved in drafting the global action plan. The plan was comprehensive and would engage all stakeholders and sectors, under the leadership of WHO, in the task of reducing the global burden of noncommunicable diseases. The draft global action plan and the draft comprehensive global monitoring framework had her delegation's full support.

Dr ALOMARI (International Federation of Red Cross and Red Crescent Societies), speaking at the invitation of the CHAIRMAN, said that the International Federation had developed a framework for noncommunicable disease prevention and control. Prevention started at the community level, where Red Cross and Red Crescent Societies played a critical role in helping people to become better informed, and better equipped to take care of their own health. His organization was leading a process of developing harmonized evidence-based tools for healthy lifestyles, which would be adapted by national branches to local contexts. Member States should strike a balance between care and prevention; ensure that prevention approaches were at the centre of all strategies; and ensure that universal health coverage and noncommunicable diseases were included in the post-2015 development agenda.

Ms Yu-Hsuan LIN (Chinese Taipei) said that Chinese Taipei had a highly efficient universal health coverage system that produced results comparable to those of the developed countries. Ensuring the sustainability of health care systems required health promotion, prevention and equitable social development. Furthermore, political engagement and social mobilization were crucial to implementing a "health-in-all-policies" approach and achieving health targets. Chinese Taipei had used benchmarking and monitoring as tools for fostering political commitment. It had included health on the development agenda, with the specific goals of reducing cancer mortality and smoking prevalence and increasing physical activity, and efforts to do so were being supported with revenue from a tobacco tax.

Ms MORTON DOHERTY (Union for International Cancer Control), speaking at the invitation of the CHAIRMAN, commended the Organization's leadership in mobilizing action to fulfil the commitments of the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases (General Assembly resolution 66/2). She called on Member States to: adopt the draft comprehensive global monitoring framework and targets for the prevention and control of noncommunicable diseases, including the 25 indicators and nine voluntary global targets, in order to ensure accountability among all stakeholders; determine action for the next phase of the global response to noncommunicable diseases by adopting the draft global action plan; agree to set up a global coordination mechanism to fill what had been a critical weakness in the response to noncommunicable diseases; integrate the global noncommunicable disease architecture into global health and development agendas, including the post-2015 framework; and ensure long-term, predictable and sustainable funding for noncommunicable disease efforts nationally and internationally.

Mr STEWART (Corporate Accountability International), speaking at the invitation of the CHAIRMAN, endorsed the draft global action plan. Powerful corporations contributed significantly to the noncommunicable disease burden, and he therefore encouraged those working to reduce the burden to continue to focus their efforts on accelerating implementation of the WHO Framework Convention on Tobacco Control and of WHO's recommendations on the marketing of foods to children. Member States should not be encouraged to enter into partnerships or accept funding from the food, tobacco and alcohol industries, in view of potential conflicts of interest and the efforts of those industries to undermine progress on the prevention and control of noncommunicable diseases. High-quality, independent research must be safeguarded, and dietary and food policy should include recommended language and codes of conduct, in order to guard against undue commercial influence.



Marketing recommendations must be backed up by statutory regulations, and actions by the private sector to self-regulate or interfere with public health policy should be monitored.

Mr BESANÇON (International Pharmaceutical Federation), speaking at the invitation of the CHAIRMAN, welcomed the emphasis in the draft global action plan on health system strengthening as essential to achieving the voluntary global targets and expressed satisfaction that counselling had been included under voluntary global target 8 as a factor in preventing heart attacks and strokes, since counselling would help to maximize the effect of medicines and other technologies and reduce costs. Pharmacists should be included in paragraph 30(h) of document A66/9 concerning the health workforce, since their advice often had a strong impact on patients. His organization, in collaboration with WHO and other stakeholders, had been assessing the status of the pharmacy workforce and working to reform pharmacy education.

Mr COLLINSWORTH (The International Association for the Study of Obesity), speaking at the invitation of the CHAIRMAN, welcomed the draft global action plan and called on Member States to adopt it. He endorsed the objective of reducing modifiable risk factors for noncommunicable diseases and welcomed the voluntary global targets relating to diet. Member States should endorse the full range of policy and regulatory options for promoting a healthy diet, as set out in paragraphs 37 to 39 of the draft global action plan. Among the actions proposed for the Secretariat in the action plan, he welcomed in particular its policy guidance role, in which it would, inter alia, provide guidance to countries concerning management of conflicts of interest at national level, and its work on developing technical tools for implementation of cost-effective interventions. He also supported the division of labour set out in Appendix 4, under which the United Nations Standing Committee on Nutrition would facilitate harmonization of action for the reduction of dietary risk of noncommunicable diseases.

Mr TOBON GARCÍA (International Federation of Medical Students' Associations), speaking at the invitation of the CHAIRMAN, welcomed the draft global action plan and the draft comprehensive global monitoring framework. Nevertheless, despite promoting a social determinants approach to noncommunicable diseases, the action plan failed to provide for specific actions to be undertaken in that regard. In implementing the plan and framework, WHO should ensure transparency, establish policies regarding conflicts of interest, and develop guidelines restricting private sector involvement in policy-making. With regard to the risk factors associated with noncommunicable diseases, the Organization should support the right of Member States to regulate trade of unhealthy products, and encourage the development of incentives for the production and consumption of healthy food and drink. Government subsidies of products that were harmful to health should be eliminated. The draft global monitoring framework placed too much emphasis on outcome indicators and would benefit from a focus on input and process indicators.

Mrs PARISOTTO (Medicus Mundi International – International Organisation for Cooperation in Health Care), speaking at the invitation of the CHAIRMAN, said that the narrow focus of the draft global action plan on four specific diseases might give rise to a vertical approach that disregarded the influence of many social, environmental and economic determinants of health. Furthermore, the global action plan explicitly called for the involvement of the private sector and failed to mention how potential conflicts of interest might be managed. Another concern was how various industries endeavoured to influence the public health agenda. To combat that, it was crucial for Member States to conduct independent analyses and evaluations of the efficacy, safety, cost-effectiveness and feasibility of public health measures, including pharmaceutical interventions. She called on Member States to take concerted action and draw up effective policies at the global and national levels to address the underlying causes of noncommunicable diseases and the structural determinants created by the current model of global economic governance.

Ms SAMSON (European Society for Medical Oncology), speaking at the invitation of the CHAIRMAN, said that with respect to cancer care, she welcomed the focus in the draft global action plan on moving beyond prevention and ensuring a full continuum of care, including early detection, treatment and palliative care. Yet, there was a risk that the action plan could increase the cancer care gap between high- and low-income countries if Member States failed to implement a comprehensive response to noncommunicable diseases. Such a response would include linking screening and early detection to an increase in health systems' treatment capacity; providing treatment options beyond the primary health care level; prioritizing the availability of basic treatment options for cancer patients in low- and middle-income countries; and including palliative care interventions and the use of morphine for pain relief in national cancer care plans. She therefore supported the call for a draft resolution on palliative care to be submitted for consideration to the Sixty-seventh World Health Assembly.

Mr OTTIGLIO (International Federation of Pharmaceutical Manufacturers and Associations), speaking at the invitation of the CHAIRMAN, said that the draft global action plan was a pragmatic document that recognized the extent of the challenge posed by noncommunicable diseases and proposed tangible measures for achieving results. Strategies that involved multiple stakeholders, were fully integrated into health care systems, and extended beyond the health sector, were needed at all levels. The pharmaceutical industry was helping to reduce the noncommunicable disease burden by developing new medicines (thousands of which were currently under study) to treat those diseases safely and effectively, and it would be glad to contribute its expertise to preparation of the proposed global coordination mechanism. On the question of conflicts of interest, the industry took the view that competing interests could be managed through declarations of interests and appropriate safeguards. The industry was working to ensure that medicines for noncommunicable diseases were available in resource-poor settings. In addition, under a recent agreement between the International Federation of Pharmaceutical Manufacturers and Associations and the International Federation of Red Cross and Red Crescent Societies, the two parties would work together to develop a behaviour change toolkit for broad distribution, which would give people the skills they needed to reduce their risk of developing noncommunicable diseases.

Ms SLOATE (GAVI Alliance), speaking at the invitation of the CHAIRMAN, said that her organization encouraged countries to work towards the voluntary global target of a 25% relative reduction in noncommunicable diseases by 2025. Evidence-based tools and interventions were needed to reach that goal, especially in resource-poor settings where access to screening and treatment was limited. Immunization had become a critical preventive factor and, in that regard, the inclusion of hepatitis B and human papillomavirus vaccines under the global monitoring framework was welcome since those vaccines, given at an early age, provided protection later on from liver cancer and cervical cancer, two of the leading causes of mortality in developing countries. The battle against noncommunicable diseases required strong partnerships and, in that framework, the GAVI Alliance would continue to broaden the reach of vaccine delivery in low-income countries.

Dr CHESTNOV (Assistant Director-General) said that adoption of the action plan would take the political process to the next level: all participants should "roll up their sleeves" and begin to put it into effect. Noncommunicable diseases provided the opportunity to improve international cooperation. Universal forces, including globalization, urbanization, poverty and population ageing, were responsible for the sudden increase in noncommunicable diseases and risk factors. The global coordination mechanism that would be developed in the coming months would reinforce the importance of international cooperation for the prevention and control of noncommunicable diseases. Ongoing research on noncommunicable diseases provided Member States with evidence-based tools and an assortment of best practices, which had been included in Appendix 3 to the draft action plan, and he urged Member States to make use of that precious resource. There was still a need for tools to support Member States' efforts to elaborate national goals for the prevention and control of noncommunicable diseases, taking account of the two global objectives included in the draft action

plan. The Secretariat was hard at work on that assignment and planned to involve Member States, research institutions, nongovernmental organizations and other partners in the process.

With regard to improving access to medical treatment for noncommunicable diseases in the developing world, he was strongly in favour of providing support to countries with developing market economies, especially through competitive pricing of quality generics. The issue was being taken up by foreign ministries and health ministries in both traditional donor States and others, including Brazil, the Russian Federation, India, China and South Africa. He urged Member States to help one another in achieving by 2025 the nine voluntary global targets included in the global action plan. For its part, WHO would provide technical support.

The DIRECTOR-GENERAL said that the consensus at which Member States had arrived with regard to the draft global monitoring framework for the prevention and control of noncommunicable diseases and its voluntary global targets represented a milestone for the Organization. In conjunction with the framework, the draft global action plan would be critical for translating political vision and commitment into action. Coordination was another essential element in implementing the global action plan at the international and country levels. Global health in the twenty-first century was a matter of multisectoral and multi-stakeholder participation. In the case of noncommunicable diseases, which was a vast field, the question was, what contributions could individual stakeholders make? Was the food industry prepared to reformulate its products to produce healthy food and to refrain from marketing unhealthy foods to young children? Above all, was the food industry prepared to refrain from interfering with government efforts to protect the public? Ministers worldwide had informed her that they were under great pressure from industry lobby groups. Engagement, participation and contributions from all sources were always welcome, but interference definitely was not. A monitoring framework and action plan for the prevention and control of noncommunicable diseases had been agreed upon by the Member States. Partners that wished to be part of that process had to operate transparently, honestly, and in full compliance with the regulations.

The Organization would strengthen its capacity, ensure that its work was based on science and technical excellence, and focus its attention on supporting countries in the implementation of the policies and the action plan. Noncommunicable diseases must be integrated with the Millennium Development Goals and with communicable diseases; otherwise the work would not be cost-effective. An integrated approach based on people-centred primary health care that addressed the social determinants of health was the way forward. Implementation was the difficult part, and the Organization needed the Member States' continued support, guidance and funding, as well as patience and understanding. She pledged to collaborate closely with other organizations in the United Nations system and with other sectors. Noncommunicable diseases threatened the development of many countries if appropriate action was not taken.

Ms JACOB (Ireland), speaking on behalf of the Member States of the European Union, expressed her appreciation to the chair of the Member States' meeting on the global monitoring framework and to the co-chairs of the drafting group for their unceasing energy and positive outlook throughout those processes. She also wished to thank the Member States and the Secretariat for their hard work and commitment. The adoption of the global action plan and the comprehensive global monitoring framework would be a milestone in WHO's collective response to the challenge posed by noncommunicable diseases.

**The meeting rose at 12:10.**

## **TWELFTH MEETING**

**Monday, 27 May 2013, at 14:30**

**Chairman:** Dr W.T. GWENIGALE (Liberia)

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

**Draft comprehensive global monitoring framework and targets for the prevention and control of noncommunicable diseases:** Item 13.1 of the Agenda (Documents A66/8 and A66/8 Add.1) (continued)

**Draft action plan for the prevention and control of noncommunicable diseases 2013–2020:** Item 13.2 of the Agenda (Documents A66/9 and A66/9 Corr.1) (continued)

Mr KLEIMAN (Brazil), welcoming the revisions to the draft global monitoring framework and the draft action plan for the prevention and control of noncommunicable diseases 2013–2020, said that approval of the nine voluntary global targets was of fundamental importance. The agreed set of global targets and indicators took into account national and regional realities and aimed to strengthen health systems and expand access to care. In that connection, he highlighted the importance of the global strategy and plan of action on public health, innovation and intellectual property and the work of the related Consultative Expert Working Group on Research and Development: Financing and Coordination in ensuring access to treatment and medication for noncommunicable diseases. By adopting the action plan, the Health Assembly would be taking a major step forward in the battle against such diseases. Although the plan was voluntary in nature, he trusted that Member States would implement it fully, with the support and leadership of the Secretariat. His delegation was proud to cosponsor the draft resolution, which fulfilled the mandate entrusted to the Organization by the High-Level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases, and looked forward to participating in future discussions on the comprehensive global monitoring framework and the related indicators.

Mr SODNOM (Mongolia), also welcoming the draft action plan, reaffirmed his Government's view that the problem of harmful use of alcohol was not being adequately addressed. He encouraged Member States to consider the possibility of developing a convention on the issue as part of the implementation of the draft action plan on noncommunicable diseases.

Dr NABEEL (Pakistan) thanked the members of the drafting group for their work and the Secretariat for its unstinting support. Once the action plan was adopted, it would be the collective duty of all to ensure its adequate implementation at national, regional and global levels.

Mr KULIKOV (Russian Federation) welcomed the draft resolution, which aimed to fulfil the commitments made under the Political Declaration of the High-level Meeting on the Prevention and Control of Non-communicable Diseases. Through its development of the comprehensive global monitoring framework and the action plan, WHO had once again played a leadership role in global health. The next steps would be to develop draft terms of reference for a global coordination mechanism and to establish a United Nations task force on noncommunicable diseases within the framework of the United Nations Economic and Social Council. His Government was preparing a draft resolution to that effect, which would shortly be distributed to Member States of the United

Nations. It was important to strengthen and support WHO's efforts for the prevention and control of noncommunicable diseases, and the Russian Federation had therefore earmarked more than US\$ 7 million for that purpose in 2012–2013; he hoped that partners would also support the Organization's work.

The CHAIRMAN said that, in the absence of any further comment, he took it that the Committee was ready to approve the draft resolution, as amended by the informal drafting group.

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

**2. PROMOTING HEALTH THROUGH THE LIFE COURSE:** Item 14 of the Agenda (continued)

**Monitoring the achievement of the health-related Millennium Development Goals and Health in the post-2015 development agenda:** Item 14.1 of the Agenda (Documents A66/13 and A66/47) (continued from the sixth meeting, section 2)

The CHAIRMAN drew attention to a revised version of the draft resolution on health in the post-2015 development agenda, which had been prepared by a drafting group and which replaced the draft resolution put forward by the Member States of the African Region during the Committee's sixth meeting. The new draft resolution read:

The Sixty-sixth World Health Assembly,

PP1 Reaffirming the WHO Constitution which states that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition;

PP2 Reaffirming the principles of the United Nations Millennium Declaration A/RES/55/2, including human dignity, equality and equity, and stressing the need for their reflection in the post-2015 development agenda;

PP3 Recalling United Nations General Assembly resolution 64/299 on "Keeping the promise: united to achieve the Millennium Development Goals", which requested the "Secretary-General to report annually on progress in the implementation of the Millennium Development Goals until 2015 and to make recommendations in his annual reports, as appropriate, for further steps to advance the United Nations development agenda beyond 2015";

PP4 Recalling United Nations General Assembly resolution 66/288 "The future we want" which recognized "health as a precondition for and an outcome and indicator of all three dimensions of sustainable development" and which requested, inter alia, the establishment of an open working group which will submit a proposal for sustainable development goals for consideration by the United Nations General Assembly;

PP5 Recognizing the global health and foreign policy resolution A/RES/67/81 which, inter alia, recommends "that consideration be given to including universal health coverage in the discussion on the post-2015 UN development agenda in the context of global health challenges";

PP6 Noting the outcome of the Global Thematic Consultation on Health in the post-2015 UN development agenda, which culminated in a High Level Dialogue on Health in Gaborone, Botswana in March 2013;

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<sup>1</sup> Transmitted to the Health Assembly in the Committee's fifth report and adopted as resolution WHA66.10.

PP7 Acknowledging the many global, regional and national consultations on health in the post-2015 UN development agenda which are now under way;

PP8 Concerned that while some countries have made good progress towards the achievement in attaining some of the health related Millennium Development Goals (MDGs) many others are not on track to fully attain some or all of the health related MDGs by 2015;

PP9 Appreciating the need to sustain current achievements and accelerate efforts in those countries where it is needed to make more rapid progress towards achievement of the health related MDGs by 2015,

1. URGES Member States:<sup>1</sup>

- (1) to ensure that health is central to the post-2015 UN development agenda;
- (2) to strengthen country ownership in articulating national plans and priorities and aligning efforts and resources towards the achievement of the current health related MDGs building towards sustainable progress on health outcomes;
- (3) to actively engage in discussions on the post-2015 UN development agenda respecting the processes established by the United Nations General Assembly;
- (4) to honour their commitments towards agreed health targets and goals and to sustain and accelerate efforts towards the achievement of the health related MDGs.
- (5) to accelerate international cooperation to support countries that may not achieve health related MDGs by 2015;

2. CALLS UPON the Director-General:

- (1) to ensure that WHO consultations on health in the post-2015 UN development agenda are inclusive and open to all regions, subregions and Member States,<sup>1</sup> and that these discussions are adequately informed by other ongoing processes;
- (2) to continue active engagement with ongoing discussions on the post-2015 UN development agenda and to work with the UN Secretary General to ensure the centrality of health in all relevant processes;
- (3) to advocate for intensified mobilization of financial and technical resources, in the spirit of the Busan Declaration on development effectiveness, to assist member states in accelerating attainment of the health related MDG targets by 2015;
- (4) to include the discussion of this agenda item, Health in the post-2015 UN development agenda, in the 2013 meetings of the WHO Regional Committees and to present a report to the Sixty-seventh World Health Assembly through the 134th Executive Board in January 2014 on these discussions.

Ms EL-HALABI (Botswana), speaking in her capacity as chair of the drafting group, said that the group had reached consensus on several underlying principles, which were reflected in the proposed amendments to the draft resolution. Switzerland and 27 Member States of the European Union had indicated that they wished to cosponsor the draft resolution, as had Brazil, subject to the inclusion of a reference in the preamble to the Rio Political Declaration on Social Determinants of Health. That amendment was acceptable to the other sponsors. She thanked the drafting group participants for their input and the Secretariat for its support.

Mr McIFF (United States of America), speaking on behalf of the Member States of the Region of the Americas, thanked the African Region for tabling the resolution and requested that the Member States of the Region of the Americas be added as cosponsors of the draft resolution, including the amendment proposed by the delegation of Brazil.

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

Ms PENIĆ-IVANKO (Croatia) said that her country would also like to cosponsor the draft resolution.

Following a request from the CHAIRMAN, Mr McIFF (United States of America) read out the new preambular paragraph *6bis* proposed by Brazil: “Further recalling the Rio Political Declaration on Social Determinants of Health, endorsed by World Health Assembly resolution WHA65.8 in May 2012”.

The CHAIRMAN said that, in the absence of any objection, he took it that the Committee wished to approve the draft resolution as amended.

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

### **3. COMMUNICABLE DISEASES: Item 16 of the Agenda (continued)**

**Neglected tropical diseases:** Item 16.2 of the Agenda (Documents A66/20 and EB132/2013/REC/1, resolution EB132.R7) (continued from the tenth meeting, section 2)

The CHAIRMAN drew attention to a revised version of the draft resolution on neglected tropical diseases, which read:

The Sixty-sixth World Health Assembly,

**PP1** Having considered the report on neglected tropical diseases,<sup>2</sup> and recalling the previous World Health Assembly resolutions listed therein;

**PP2** Recognizing that increased national and international investments in prevention and control of neglected tropical diseases have succeeded in improving health and social well-being in many countries;

**PP2(bis) Recognizing the importance of the Global Plan to Combat Neglected Tropical Diseases 2008–2015; [Brazil]**

**PP3** Noting WHO’s roadmap to accelerate the work to overcome the global impact of neglected tropical diseases ~~and the subsequent London Declaration on Neglected Tropical Diseases endorsed by a community of partners; [Zimbabwe/India]~~

**PP4** Acknowledging the linkages between, and mutual supportiveness of, control and elimination of neglected tropical diseases and the global strategy and plan of action on public health, innovation and intellectual property;

**PP5** Acknowledging that expansion of activities to prevent and control neglected tropical diseases will need adequately resourced national programmes functioning within effective health, education and other sectors in order to provide for an uninterrupted supply and delivery of quality-assured commodities and services;

**PP6** Realizing that current approaches to the prevention and control of neglected tropical diseases, when implemented in an integrated manner and across all relevant sectors, are highly effective and contribute to stronger health systems and the achievement of the health-related Millennium Development Goals, but that there are still many challenges;

**PP7** Appreciating the generous contribution of pharmaceutical companies in donating sufficient quantities of quality-assured essential medicines for the prevention and treatment of

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<sup>1</sup> Transmitted to the Health Assembly in the Committee’s fifth report and adopted as resolution WHA66.11.

<sup>2</sup> Document A66/20.

neglected tropical diseases, while acknowledging the need to ensure their continuous availability and affordability;

**PP8** Recognizing the contribution of bodies in the United Nations system, intergovernmental and nongovernmental organizations, academic institutions and civil society;

**PP9** Recognizing the diversity of neglected tropical diseases, their causative agents and relevant vectors and intermediate hosts, their epidemic potential (such as for dengue, Chagas disease, human rabies of canine origin and leishmaniasis), and their morbidity, mortality and associated stigmatization,

1. URGES Member States:

(1) to ensure **continued [India]** country ownership of programmes for neglected tropical disease prevention, control, elimination and eradication;

**(1bis) to further strengthen the disease surveillance system especially on neglected tropical diseases targeted for eradication; [Thailand]**

(2) to expand and implement, as appropriate, interventions against neglected tropical diseases in order to reach the targets agreed ~~by all partners in the Global Plan to Combat Neglected Tropical Diseases 2008–2015, taking into account [Brazil]~~ the London Declaration on Neglected Tropical Diseases and set out in WHO's roadmap for accelerating work to overcome the global impact of neglected tropical diseases by:

(a) ensuring that resources match national requirements and flow in a sustainable manner as a result of thorough planning and costing of prevention and control activities and detailed analysis of associated expenditures;

(b) enabling improvement of the management of the supply chain, in particular through forecasting, timely procurement of quality-assured goods, improved stock-management systems, and facilitating importation and customs clearance;

(c) integrating neglected tropical diseases control programmes into primary health care services and vaccination campaigns, or into existing programmes where feasible, in order to achieve greater coverage and reduce operational costs;

(d) ensuring appropriate programme management and implementation through the development, sustenance and supervision of a cadre of skilled staff (including other sectors than health) at national, district and community levels;

(3) to advocate predictable, long-term, international financing for the control of neglected tropical diseases; to enhance and sustain national financial commitments, including resource mobilization from sectors other than health; and to strengthen capacity for prevention and control of neglected tropical diseases, strengthening research, in order to accelerate implementation of the policies and strategies designed to achieve the targets set by the Health Assembly in various resolutions related to specific neglected tropical diseases as well as in the roadmap and the London Declaration;

(4) to strengthen national capacity for monitoring and evaluation of the impact of interventions against neglected tropical diseases;

(5) to devise plans for achieving and maintaining universal access to and coverage with interventions against neglected tropical diseases, notably:

(a) to provide prompt diagnostic testing of all suspected cases of neglected tropical diseases and effective treatment with appropriate therapy of patients in both the public and private sectors at all levels of the health system including the community level;



- (b) to implement and sustain coverage with preventive chemotherapy<sup>1</sup> of at least 75% of the populations in need, as a prerequisite for achieving goals of disease control or elimination;
  - (c) to improve coordination for reducing transmission and strengthening control of neglected tropical diseases **taking into account social determinants of health, [India]** through provision of safe drinking-water, basic sanitation, health promotion and education, vector control and veterinary public health; **taking into consideration One Health [Thailand];**
2. CALLS upon WHO's international partners, including intergovernmental, international and nongovernmental organizations, financing bodies, academic and research institutions, civil society and the private sector:
- (1) to support Member States, as appropriate:
    - (a) to provide sufficient and predictable funding to enable the targets for 2015 and 2020 to be met and efforts to control neglected tropical diseases to be sustained;
    - (b) to harmonize the provision of support to countries for implementing a national plan based on WHO-recommended policies and strategies and using commodities that meet international quality standards;
    - (c) to promote universal access to preventive chemotherapy, and diagnostics, case management, and vector control and other prevention measures, as well as effective surveillance systems;
  - (2) to encourage initiatives for the ~~discovery~~ **research [India]** and development of new diagnostics, medicines, vaccines, and pesticides and biocides, improved tools and technologies and other innovative instruments for vector control and infection prevention and to support operational research to increase the efficiency and cost-effectiveness of interventions, taking into account the global strategy and plan of action on public health, innovation and intellectual property;
  - (3) to collaborate with WHO in order to provide support to Member States in measuring progress towards, and in accomplishing, their goals of elimination and eradication of selected neglected tropical diseases;
3. REQUESTS the Director-General:
- (1) to sustain WHO's leadership in the drive to overcome neglected tropical diseases;
  - (2) to support the development and updating of evidence-based norms, standards, policies, guidelines and strategies and research for prevention, control and elimination of neglected tropical diseases in order to chart a course for reaching the related targets set in resolutions of the Health Assembly;
  - (3) to monitor progress in achieving the targets for neglected tropical diseases set in WHO's roadmap for accelerating work to overcome the global impact of neglected tropical diseases, and to provide support to Member States in their efforts to collect, validate and analyse data from national surveillance systems;
  - (4) to provide support to Member States to strengthen human resource capacity for prevention, diagnosis and control of neglected tropical diseases, including vector control and veterinary public health;
  - (5) to encourage and support initiatives to discover and obtain new diagnostic tools, medicines and ~~insecticides~~ **vector control measures, [India]** and to support operational research to increase the efficacy and cost-effectiveness of interventions;

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<sup>1</sup> Preventive chemotherapy means large-scale preventive treatment against helminthiases and trachoma with safe, single-dose, quality-assured medicines.

(6) to report to the Sixty-eighth World Health Assembly on progress towards the elimination and eradication of targeted diseases, through the Executive Board.

Mr DJOULDE (Cameroon), speaking on behalf of the Member States of the African Region, voiced strong support for the revised draft resolution. He drew attention to the devastating impact of noma on people in Africa and also in Asia and Latin America, noting not only its link to malnutrition but also its association with poverty, in common with other neglected tropical diseases. He therefore recommended that WHO accord higher priority to the issue of noma and that the Secretariat draw up a report on the subject for consideration by the next Health Assembly.

Dr BUSUMANI (Zimbabwe) proposed amending subparagraph 1(2) by deleting “taking into account the London Declaration on Neglected Tropical Diseases” after “2008–2015”.

Mr PUSP (India) expressed support for the amendment proposed by the delegate of Zimbabwe. If the Committee was not able to accept that amendment, however, he would propose replacing “taking into account” with “noting” and changing the order of the words in order to refer first to WHO’s roadmap and then to the London Declaration.

Dr LANE (United Kingdom of Britain and Northern Ireland) said that his delegation could not agree to the amendment proposed by the delegate of Zimbabwe but would accept the wording proposed by the delegate of India.

Dr BUSUMANI (Zimbabwe) agreed to the amendment proposed by the delegate of India.

Responding to a request from the CHAIRMAN, Mr PUSP (India), said that subparagraph 1(2) as amended would read: “... 2008–2015, as set out in WHO’s roadmap for accelerating work to overcome the global impact of neglected tropical diseases and noting the London Declaration on Neglected Tropical Diseases by:”.

The CHAIRMAN said that, in the absence of any objection, he took it that the Committee was ready to approve the draft resolution as amended.

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

**The meeting was suspended at 15:00 and resumed at 15:45.**

#### **4. FIFTH REPORT OF COMMITTEE A (Document A66/73)**

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

The CHAIRMAN said that, in the absence of any objection, he took it that the Committee wished to adopt the report.

**The report was adopted.<sup>2</sup>**

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<sup>1</sup> Transmitted to the Health Assembly in the Committee’s fifth report and adopted as resolution WHA66.12.

<sup>2</sup> See page 310.

**5. CLOSURE OF THE MEETING**

After the customary exchange of courtesies, the CHAIRMAN declared the work of Committee A completed.

**The meeting rose at 15:50.**

## **COMMITTEE B**

### **FIRST MEETING**

**Wednesday, 22 May 2013, at 14:40**

**Chairman:** Mrs K. TYSON (United Kingdom of Great Britain and Northern Ireland)

#### **1. OPENING OF THE COMMITTEE:** Item 19 of the Agenda

The CHAIRMAN welcomed participants and Dr Jamal Thabet Nasher (Yemen), who, as Chairman of the Programme, Budget and Administration Committee of the Executive Board, would report on several items on the agenda dealt with on behalf of the Executive Board by that Committee at its eighteenth meeting (Geneva, 16 and 17 May 2013).

#### **Election of Vice-Chairmen and Rapporteur**

The CHAIRMAN informed the Committee that Dr Daisy Corrales Díaz (Costa Rica) and Dr Poonam Khetrpal Singh (India) had been nominated for the offices of Vice-Chairmen of Committee B, and Mr Jilali Hazim (Morocco) for the office of Rapporteur.

**Decision:** Committee B elected Dr Daisy Corrales Díaz (Costa Rica) and Dr Poonam Khetrpal Singh (India) as Vice-Chairmen, and Mr Jilali Hazim (Morocco) as Rapporteur.<sup>1</sup>

#### **2. ORGANIZATION OF WORK**

The CHAIRMAN appealed to speakers to limit their statements to three minutes. As at previous meetings, timing would be indicated by a traffic-light system.

Following a request received by the Secretariat, it was proposed that consideration of agenda item 24.4 on reassignment of South Sudan from the Eastern Mediterranean Region to the African Region should be brought forward. She therefore suggested that it be taken up at the next meeting.<sup>2</sup> The remaining agenda items allocated to the Committee would then be dealt with in the order in which they appeared in the agenda, document A66/1 Rev.1.

**It was so agreed.**

Ms HAGERTY (Ireland), speaking on behalf of the European Union, noted that the European Union worked closely with WHO on a wide range of issues both within the European Region and at the global level. In view of the exchange of letters in 2000 between WHO and the European Commission concerning the consolidation and intensification of cooperation, and without prejudice to any future conclusion of a general agreement between WHO and the European Union, she requested

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<sup>1</sup> Decision WHA66(5).

<sup>2</sup> See the summary record of the second meeting, section 3.

that, in accordance with Rule 46 of the Rules of Procedure of the World Health Assembly and as on previous occasions, the European Union should be invited to participate as an observer, without vote, in the meetings of the Health Assembly, its committees and subcommittees or other subdivisions dealing with matters within the competence of the European Union.

**It was so agreed.**

**3. HEALTH CONDITIONS IN THE OCCUPIED PALESTINIAN TERRITORY, INCLUDING EAST JERUSALEM, AND IN THE OCCUPIED SYRIAN GOLAN:**  
Item 20 of the Agenda (Documents A66/28, A66/INF./1, A66/INF./2, A66/INF./3 and A66/INF./4)

The CHAIRMAN drew attention to a draft resolution proposed by the delegations of Algeria, Bahrain, Djibouti, Egypt, Iraq, Jordan, Kuwait, Libya, Maldives, Mauritania, Morocco, Oman, Pakistan, Palestine, Qatar, Saudi Arabia, Tunisia, Turkey, United Arab Emirates, and Yemen, which read:

The Sixty-sixth World Health Assembly,

PP1 Mindful of the basic principle established in the Constitution of WHO, which affirms that the health of all peoples is fundamental to the attainment of peace and security;

PP2 Recalling all its previous resolutions on health conditions in the occupied Palestinian territory and other Arab occupied territories;

PP3 Taking note of the report of the Secretariat on the health conditions in the occupied Palestinian territory, including east Jerusalem;<sup>1</sup>

PP4 Stressing the essential role of UNRWA in providing crucial health and education services in the occupied Palestinian territory, particularly in addressing the emergency needs in the Gaza Strip;

PP5 Expressing its concern at the deterioration of economic and health conditions as well as the humanitarian crisis resulting from the continued occupation and the severe restrictions imposed by Israel, the occupying power;

PP6 Affirming the need to guarantee universal coverage of health services and to preserve the functions of the public health services in the occupied Palestinian Territory;

PP7 Recognizing that the acute shortage of financial and medical resources in the Palestinian Ministry of Health, which is responsible for running and financing public health services, jeopardizes the access of the Palestinian population to curative and preventive services;

PP8 Affirming the right of Palestinian patients, medical staff and ambulances to have access to the Palestinian health institutions in occupied east Jerusalem;

PP9 Affirming that the blockade is continuing and that the crossing points are not entirely and definitely opened, meaning that the crisis and suffering that started before the Israeli attack on the Gaza Strip are continuing, hindering the efforts of the Ministry of Health of the Palestinian Authority to reconstruct the establishments destroyed by the Israeli military operations by the end of 2008 and in 2009;

PP10 Expressing deep concern at the grave implications of the wall on the accessibility and quality of medical services received by the Palestinian population in the occupied Palestinian territory, including east Jerusalem;

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<sup>1</sup> Document A66/28.

1. DEMANDS that Israel, the occupying power:
  - (1) immediately put an end to the closure of the occupied Palestinian territory, particularly the closure of the crossing points of the occupied Gaza Strip that is causing the serious shortage of medicines and medical supplies therein;
  - (2) abandon its policies and measures that have led to the prevailing dire health conditions and severe food and fuel shortages in the Gaza Strip;
  - (3) comply with the Advisory Opinion rendered on 9 July 2004 by the International Court of Justice on the wall which, inter alia, has grave implications for the accessibility and quality of medical services received by the Palestinian population in the occupied Palestinian territory, including east Jerusalem;
  - (4) facilitate the access of Palestinian patients, medical staff and ambulances to the Palestinian health institutions in occupied east Jerusalem and abroad;
  - (5) improve the living and medical conditions of Palestinian detainees, particularly children, women and patients, and provide the detainees who are suffering from serious medical conditions worsening every day with the necessary medical treatment and facilitate the transit and entry of medicine and medical equipment to the occupied Palestinian territory;
  - (6) respect and facilitate the mandate and work of UNRWA and other international organizations, and ensure the free movement of their staff and aid supplies;
2. URGES Member States and intergovernmental and nongovernmental organizations:
  - (1) to help overcome the health crisis in the occupied Palestinian territory by providing assistance to the Palestinian people;
  - (2) to help meet urgent health and humanitarian needs, as well as the important health-related needs for the medium term and long term, as identified in the relevant reports of the Director-General including her report on the specialized health mission to the Gaza Strip;
  - (3) to call upon the international community to exert pressure on the Government of Israel to lift the siege imposed on the occupied Gaza Strip in order to avoid a serious exacerbation of the humanitarian crisis therein and to help lift the restrictions and obstacles imposed on the Palestinian people including the free movement of people and medical staff in the occupied Palestinian territory, and to bring Israel to respect its legal and moral responsibilities and ensure the full enjoyment of basic human rights for civilian populations in the occupied Palestinian territory, particularly in east Jerusalem;
  - (4) to remind Israel, the occupying power, to abide by the Fourth Geneva Convention relative to the Protection of Civilian Persons in Time of War of 1949, that is applicable to the occupied Palestinian territory including east Jerusalem;
  - (5) to call upon all international humanitarian and human rights organizations, to intervene on an urgent and immediate basis vis-à-vis the occupying power, Israel, and compel it to provide adequate medical treatment to Palestinian prisoners and detainees who are suffering from serious medical conditions worsening every day, and urges civil society organizations to exercise pressure on the occupying power, Israel, to save the lives of detainees and ensure the immediate release of critical cases and to provide them with external treatment, and to allow Palestinian women prisoners to receive maternity care services and medical follow up during pregnancy, delivery and postpartum care, and to allow them to give birth in healthy and humanitarian conditions in the presence of their relatives and family members and immediately to release all children detained in Israeli prisons;
  - (6) to support and assist the Palestinian Ministry of Health in carrying out its duties, including running and financing public health services;
  - (7) to provide financial and technical support to the Palestinian public health sector;

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

<p><b>1. Resolution:</b> Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan</p>	
<p><b>2. Linkage to the Programme budget 2012–2013 (see document A64/7 <a href="http://apps.who.int/gb/ebwha/pdf_files/WHA64/A64_7-en.pdf">http://apps.who.int/gb/ebwha/pdf_files/WHA64/A64_7-en.pdf</a>)</b></p> <p>Strategic objective(s): all</p> <p>Organization-wide expected result(s): all</p> <p><b>How would this resolution contribute to the achievement of the Organization-wide expected result(s)?</b></p> <p>This resolution contributes to the achievement of the Organization's expected results in communicable diseases, noncommunicable diseases, health through the life-course, health systems strengthening and preparedness, surveillance, and response.</p> <p><b>Does the programme budget already include the products or services requested in this resolution? (Yes/no)</b></p> <p>Yes.</p>	
<p><b>3. Estimated cost and staffing implications in relation to the Programme budget</b></p> <p><b>(a) Total cost</b></p> <p><b>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).</b></p> <p>(i) One year (covering the period mid-2013 to mid-2014)</p> <p>(ii) Total: US\$ 8.34 million (staff and activities)</p>	

**(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\$ 4.87 million (staff and activities)

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

The activities will be primarily implemented through the WHO Office in Jerusalem, which is responsible for WHO's cooperation programme with the Palestinian Authority. WHO's activities in the field will be supplemented by support from the Regional Office for the Eastern Mediterranean, and by the headquarters clusters involved in work on poliomyelitis, emergencies and country cooperation, and by those working on health security and the environment.

**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)**

Yes.

**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.**

**4. Funding**

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

No.

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

Funding gap: US\$ 1.59 million; source(s) of funds: funding will continue to be sought through voluntary contributions, including the Consolidated Appeal Process; critical funding gaps may in part be closed through assessed contributions.

Mrs BASSIM (Egypt), introducing the draft resolution on behalf of the Member States of the Eastern Mediterranean Region and Algeria, Maldives and Turkey, said that it dealt with the deteriorating health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan caused by the continuing Israeli occupation policies and practices. The draft resolution was consistent with the purposes and principles of the WHO Constitution, which reaffirmed that the health of all peoples was fundamental to the attainment of peace and security, and with previous Health Assembly resolutions on health conditions in the occupied Arab territories, which enshrined a moral and ethical commitment on the part of all Member States and reflected the will of the international community. It offered a way for WHO to shoulder its responsibilities, in order to guarantee the delivery of essential health services to the Palestinian and Syrian peoples living under occupation.

She drew particular attention to the demands made of Israel, the occupying power, in paragraph 1 and to the appeals directed to Member States and intergovernmental and nongovernmental organizations in paragraphs 2(1), 2(3), 2(5) and 2(6). The sponsors of the draft resolution had agreed by consensus on its content, engaging in informal consultations with delegations of Member States from all regions and focusing on the need for technical assistance to be provided to the populations concerned. With regard to the worsening humanitarian crisis afflicting the Syrian people, she said that the Golan constituted occupied Syrian territory, and Israel, as the occupying power, was required to comply with its international obligations to guarantee health services for the inhabitants. She trusted



that the Health Assembly would send a strong message to the international community concerning the right to the highest standards of health for all, including people living under occupation.

Mr ZUHAIRI (Palestine) drew attention to statements issued that day in the Israeli media to the effect that the Palestinians were taking unilateral action by submitting a draft resolution to the Health Assembly condemning Israel. Israel was thus depicting itself as a victim. The draft resolution actually contained appeals to the international community through the Health Assembly and expressions of support for regional and international efforts to assist the Palestinian people, who wished to have their own independent and sovereign State instead of living under occupation. When that day came, Palestine would no longer require such a resolution but could engage in its own efforts, with WHO support, to fight disease and to implement international treaties. Under the current circumstances, it was merely asking the occupying power to respect the Charter of the United Nations, the Universal Declaration of Human Rights, the two International Covenants on Human Rights, the Declaration of Alma-Ata, the Ottawa Charter, the Bangkok Charter and the Fourth Geneva Convention.

Pursuant to the Third Protocol to the Geneva Conventions concerning the adoption of an additional distinctive emblem, agreement had been reached in 2011 between the Palestinian Red Crescent Society and the Israeli Magen David Adom, and the Israeli society now seemed to be willing to cooperate with its Palestinian counterpart. The Israeli Ministry of Health had also held a series of meetings with the Palestinian Ministry of Health. However, all such initiatives had met with resistance from the Israeli political authorities and security forces. Nonetheless, health should serve as a bridge for building peace and providing humanitarian protection.

He urged Member States to support the draft resolution as a contribution to the rule of law. In doing so they would actually be assisting Israel, which currently acted as though it were above the law. Lastly, he referred to the fact that three Palestinian detainees had died in Israeli detention centres since the beginning of 2013 because of lack of medicines. Moreover, the International Committee of the Red Cross had registered 900 detainees as suffering from chronic and incurable diseases but not receiving care; he urged Member States to call for their immediate release.

Mr CHU Guang (China) said that the health conditions of the Palestinian people were still a matter of grave concern to China and the humanitarian situation was serious. China appreciated the efforts of WHO to improve health conditions in the occupied Palestinian territory and their positive results. It was also concerned about the health status of Palestinian detainees in Israeli prisons and called upon Israel to improve their living and health conditions, and to take effective measures to avoid acts that could lead to tension, such as malicious arrest. He further called on Israel to improve the humanitarian situation in the occupied territory and do all it could to resolve problems through political means. He appealed to the relevant countries to allow WHO to enter the occupied Syrian Golan. He supported the draft resolution.

Mr BAGHERPOUR (Islamic Republic of Iran) thanked the Secretariat for its continuing efforts to improve health conditions in the occupied Palestinian territory. The occupation, the resulting restrictions on movement and on imports and exports, and low private sector investment, had produced some of the highest rates of unemployment and poverty in the world, which were adversely affecting the health of the population and causing economic and social hardship. The denial of or lack of response to requests for permits to travel for medical treatment, as noted in the Secretariat's report, was contrary to WHO objectives and principles. The serious health and humanitarian needs of Palestinian prisoners held in Israeli jails, especially those who were ill and on hunger strike, were alarming, and the Secretariat should systematically monitor their situation and report to the Health Assembly on a regular basis.

He expressed deep concern that WHO was denied access to the occupied Syrian Golan: the international community had a duty to monitor health conditions there, and WHO should be guaranteed access in order to do so. The world should not stand idly by while a whole population was deprived of its most basic needs: the international community must do everything in its power to put

pressure on the occupiers to lift the restrictions on Palestinians, including those related to travel and free access to goods and medical services in the occupied Palestinian territory. The international community should come together to find a resolution to the situation and help end decades of occupation.

Mr AMRI BUKHAIRI BAKHTIAR (Malaysia) commended the work done by the Secretariat and several Member States to improve the public health system and provide health-related technical assistance to people in the occupied Palestinian territory. His country was deeply concerned about the deterioration of economic and health conditions outlined in the Secretariat's report, which clearly resulted from the severe restrictions imposed by the occupying power. The obstacles impeding access by the Palestinian people to their basic right to health care, including the complicated process for referral permission, were unacceptable and violated international humanitarian law. He deeply regretted that efforts to establish medical centres in the occupied Syrian Golan continued to be frustrated by the Israeli occupation forces and was especially concerned that there were reported to be radioactive nuclear landfills in the area that could have a negative environmental and health impact. There was therefore an acute need to guarantee universal coverage of health services and to preserve the functions of the public health services in the occupied Palestinian territory and Syrian Golan. As evidence of its strong support, his country also wished to sponsor the draft resolution.

Mr DEMIRALP (Turkey) expressed his country's extreme concern about the health conditions in the occupied Palestinian territory. He noted with regret that the main health concerns continued to stem from preventable causes closely associated with the occupation. It was also regrettable that patients could not easily be referred elsewhere for specialized treatment and that there was a substantial shortage of medicines and medical supplies. The health conditions of Palestinian prisoners in Israeli jails were a further cause for concern.

The Constitution of the World Health Organization declared that the enjoyment of the highest attainable standard of health was one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition, but the Palestinian people had for years faced appalling health conditions, especially in the Gaza Strip, which was under illegal blockade. He appreciated the efforts of WHO and other organizations of the United Nations system to alleviate the sufferings of the Palestinian people, but they were mainly aimed at improving existing health conditions in Palestine. Although a great deal could be achieved by following that path in normal circumstances, the conditions in the occupied territory were extraordinary: Palestine was a bleeding wound in the conscience of all humanity.

The WHO Constitution also stated that the health of all peoples was fundamental to the attainment of peace and security and was dependent upon the fullest cooperation of individuals and States. He therefore strongly urged that meaningful steps be taken to lift the obstacles to basic foodstuffs and medical products reaching the Palestinian people. Turkey was ready to work unstintingly to achieve the WHO objective of the attainment by all peoples of the highest possible level of health through efforts to realize universal health coverage, to decrease the risk factors for noncommunicable diseases and to help overcome the health crisis faced by the Palestinian people. Turkey was a sponsor of the draft resolution and invited all Member States to support it.

Mr MINTY (South Africa) fully appreciated the work undertaken by WHO despite the challenge of having no access to the occupied Syrian Golan. He remained gravely concerned about the Israeli settlement policy in the territory: the restrictions imposed on the movement of the Palestinian people had a negative impact on economic and social development in the occupied territory, which in turn adversely affected the health status of the Palestinian people. It was also extremely worrying that the differences in poverty rate and health status gaps in the West Bank and the Gaza Strip were widening. The report indicated that the leading causes of death were cardiovascular disease, cancer, cerebrovascular disease and diabetes, and that the prevalences of noncommunicable diseases and their risk factors were high, but there was no doubt that the conflict had increased the number of people

suffering from mental health-related illnesses and left physically disabled. The inhumane restrictions on movement adversely affected patients' general well-being, as well as their access to the medical care that their respective situations warranted. Israel must end all restrictions impeding the free movement of people and preventing their access to health services.

It was accordingly essential to implement resolution WHA65.9, which, among other things, demanded that Israel immediately put an end to the closure of the occupied Palestinian territory, particularly the closure of the crossing points of the occupied Gaza Strip that was causing the serious shortage of medicines and medical supplies therein; abandon its policies and measures that had led to the prevailing dire health conditions and severe food and fuel shortages in the Gaza Strip; and facilitate the access of Palestinian patients, medical staff and ambulances to the Palestinian health institutions in occupied east Jerusalem. He reiterated his country's support for the establishment of medical facilities and provision of health-related technical assistance to the Syrian population in the occupied Syrian Golan. WHO and the international community should continue to assist the Palestinian people with their health needs to the greatest extent possible. He supported the draft resolution.

Dr NABEEL (Pakistan) was deeply concerned at the health situation in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan. High levels of poverty and unemployment continued in the occupied Palestinian territory, which was on the brink of a humanitarian crisis. He condemned the continuing deaths and injuries resulting from the occupation. The Gaza Strip remained largely isolated from the outside world as a result of the policy of external closure, which had resulted in reduced access to secondary and tertiary health care, and a lack of essential supplies and medicines. The blockade had led to the degradation of health infrastructure, poorer performance of the health sector and a deterioration in essential primary health care programmes, such as those for maternal and child health.

WHO's health-related technical assistance, information and coordination services to the Palestinian people were appreciated, but more must be done to stem the fast-developing health emergency. The scope of WHO technical support to UNRWA should be enhanced, and it was important to use the Organization's influence with donors to ease the funding crisis, which had a direct impact on the health of innocent civilians, including women and children. The Health Assembly should send a strong message calling for an end to the economic and political repression that continued to jeopardize access to and provision of health services to the people in the occupied territory. Pakistan was a sponsor of the draft resolution and strongly urged the international community to support the Palestinian people and make concerted efforts towards a just, comprehensive and lasting peace.

Dr AL-NAYEF (Syrian Arab Republic) said that the health conditions of Syrians living in the occupied Syrian Golan were deteriorating at an alarming pace owing to the Israeli occupation and oppressive practices. For instance, Syrians who were unwilling to accept Israeli citizenship were denied medical treatment, and there was an acute shortage of primary and secondary health care services owing to the lack of integrated medical centres. Syrians and Palestinians in Israeli prisons continued to be held in inhumane conditions, which exposed them to serious illnesses and permanent disabilities. Furthermore, Arab and Syrian detainees continued to be used for testing medicines, and were tortured and coerced into confessing crimes that they had never committed. Prisoners were also injected with dangerous viruses that caused them to develop diseases and disabilities and could even prove fatal. In addition, the Israeli occupation authorities continued to bury toxic substances at numerous sites in the occupied Syrian Golan and to plant the ceasefire line with various types of landmines. The negative impact of such practices on human health through pollution of the soil and groundwater was well known. They constituted violations of all international and humanitarian norms and treaties. The Ministry of Health of the Syrian Arab Republic held the Israeli occupation authorities fully responsible for any environmental or health-related complications in Golan villages resulting from the burial of toxic wastes.

In recent years the Israeli occupation authorities had ignored repeated Syrian requests to provide medical services to Syrian citizens in the occupied Golan. Their underlying objective was to exert pressure on the villagers so that they could be expelled or forced to accept Israeli citizenship. The international community had failed to live up to its responsibility to protect the rights of Syrian citizens in the occupied Golan, particularly their right to health. WHO should take immediate effective action to halt inhumane Israeli practices that targeted the health of Syrian citizens. His country had always respected the prerogatives and competences of WHO and had tried to avoid politicizing the issue, an approach that Israel had rejected. Such conduct reflected that country's disdain for all international legal principles and the Geneva Conventions. He urged all Member States to support the draft resolution, which called for international law to be respected.

Dr AHMED (Bangladesh) said that a deterioration of health conditions in any region of the world was unacceptable, and that applied to the occupied Palestinian territory, including east Jerusalem, and the Syrian Golan, where people were suffering. The draft resolution was necessary and was in line with the Declaration of Alma-Ata and international conventions; he therefore supported it.

Mr MANOR (Israel) recalled that since its establishment 65 years before, WHO had rightly earned a reputation as a professional organization strictly focused on its vital task of advancing global public health. Regrettably, that reputation was tarnished every year by a debate and resolution entitled "Health conditions in the occupied Palestinian territory, including east Jerusalem, and the occupied Syrian Golan". Israel's position had consistently been that a politically motivated debate and resolution singling out one country conflict out of many the world over side-tracked the Health Assembly and should have no place on its agenda. The health situation in the Palestinian territories had improved steadily according to established international indicators, while all residents of the Golan Heights enjoyed the very high quality of medical services available to all residents of Israel. It was high time that WHO turned its attention and limited financial resources to those regions in which its involvement was really required. That was all the more so in view of the situation in the Syrian Arab Republic, where the medical crisis was of dramatic proportions. At a time when there was enormous human suffering and destruction of infrastructure in the Syrian Arab Republic, it was absurd that the Committee was wasting its precious time on the excellent health conditions of the residents of the Golan. For those reasons, he requested a roll-call vote on the draft resolution and urged all Member States to vote against it and to decide instead not to raise the matter at future Health Assemblies.

Dr AL HINAI (Oman) said that his country was aware of the enormous challenges faced by the health sector in the occupied Palestinian territory and the occupied Syrian Golan as a result of unemployment, poverty and lack of funds. He commended WHO's efforts to provide technical advice and support to the Palestinian Ministry of Health in priority areas such as public health, primary health care services and hospitals, and urged the Organization to intensify its technical support, especially in the area of noncommunicable diseases, which were the main causes of morbidity and death in the occupied Palestinian territory. Oman shared WHO's concern about the health conditions of Palestinian prisoners in Israeli jails and encouraged it to intensify its efforts to ensure that prisoners who were ill or on hunger strike received the requisite care. Noting that WHO was unable to report on the health situation in the occupied Syrian Golan, he urged the Secretariat to persist with its efforts to obtain information from both parties concerned.

Ms BLACKWOOD (United States of America) was disappointed that such a resolution was again before the Committee, bringing political matters into the global health body. It neither contributed to the improved health of Palestinians nor made progress towards Israeli-Palestinian peace. Her country remained committed to the goal of two states living side by side in peace and security.

The United States of America was the largest bilateral donor to UNRWA and its contribution helped provide primary health care services in the Gaza Strip and the West Bank through the operation of clinics and the provision of subsidized hospital care. Her country's support also helped to ensure water and sanitation services for refugee communities and to provide counselling and mental health support to vulnerable refugees, particularly children and young people. The United States of America also provided direct bilateral assistance to Palestinians in the West Bank and the Gaza Strip through the United States Agency for International Development, which helped to improve overall quality of life and to strengthen local capacity. Projects were aimed at infrastructure development, education, economic growth, humanitarian assistance and health sector development. In 2012, the Agency's budget for assistance to the West Bank and the Gaza Strip had amounted to some US\$ 396 million.

Her country remained concerned about conditions in the Gaza Strip but noted the increases in the range and scope of goods and materials going into the area, an increase in international reconstruction activity, and a gradual expansion of exports. The United States of America would continue to work with Israel, the Palestinians and others to advance the needs of the people of the Gaza Strip, and encouraged other countries to join it in that effort. She believed the draft resolution to be biased and overly political, and it did not acknowledge the cooperation that could and did take place between Israel and the Palestinians. While she opposed the draft resolution, that in no way indicated a lack of her country's commitment to the welfare of the Palestinian people.

Mr AL-SHEHABI (Bahrain) expressed deep concern about the hardship inflicted on the Palestinian Authority and its Ministry of Health by deteriorating health and economic conditions, which had an adverse impact on integrated health care services. He drew attention in particular to the shortage of medicines, consumer goods and energy supplies in the West Bank and the Gaza Strip, the increasing prevalence of noncommunicable diseases and associated risk factors, and the higher incidence rates for communicable diseases. He urged the Director-General to continue supporting the Palestinian Ministry of Health and stressed the importance of taking steps to meet urgent health requirements stemming from the continued Israeli occupation, especially those relating to the lack of medicines. It was essential to facilitate access to treatment, ambulances and basic health services for the most vulnerable groups, to provide enhanced protection for civilians and health sector employees, and to build capacity to deal with emergencies and disasters. He encouraged Member States to support the draft resolution.

Mr HAIDAR (Lebanon) said that his country wished to be included as a sponsor of the draft resolution.

Mr OQUIST KELLEY (Nicaragua) asserted that political will for peace on the part of Israel would solve the problems outlined in the Secretariat's report. The health situation in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan was distorted by the occupation, the blockade of Gaza, the eviction from their homes of families in east Jerusalem, and the growth of illegal settlements in Palestinian territory. The health of Palestinians and Syrians in Israeli prisons was also cause for concern. The situation affected everyone, because there could be no peace in the world without peace in the Middle East, and there could be no peace in the Middle East without peace and justice for the Palestinian people in a Palestinian state with east Jerusalem as its capital. He fully supported the draft resolution.

Mr ROMERO PUENTES (Cuba) expressed his grave concern about the health deficiencies highlighted in the report. He supported the draft resolution and commended its sponsors, to whose number Cuba wished to be added. The suffering of the Palestinian people amounted to an ongoing genocide and the Health Assembly should take a stand on their health situation, not only because the resolution would help the Organization to achieve its goals concerning communicable and noncommunicable diseases, health throughout the life course and strengthening health systems, but also because that would send a clear message of protection of the Palestinian people by the

international community and rejection of the occupying power's violation of its international obligations. When the right of the Palestinian people to self-determination was respected, there would be no need to submit and approve a draft resolution such as the one under consideration. Unfortunately, the complicity of the military superpower with that situation of genocide again made it necessary to condemn such an attitude and send a message of protection of the Palestinian people.

Mr BOUGACHA (Tunisia) expressed deep concern about the deteriorating health conditions and services in the occupied Palestinian territory, including east Jerusalem, and the occupied Syrian Golan. He commended WHO, and especially the Regional Office for the Eastern Mediterranean, on their efforts to alleviate the sufferings of the Palestinian people and urged them to continue and intensify them. He thanked the Palestinian delegation for the flexibility it had demonstrated in its negotiations on the draft resolution, and called on all Member States to support it so that WHO could continue to provide assistance to the Palestinian people, the only people who had been subjected to occupation for more than 65 years. Quite apart from any political considerations, that fact fully justified, in technical terms, the adoption of the draft resolution, and all charges of a conspiracy could be dismissed.

Mr BAMBANG GURITNO (Indonesia) expressed his country's deepest concern regarding the health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan, as described in document A66/28. He fully supported the draft resolution.

Mr ALBARRÁN DE PABLO (Bolivarian Republic of Venezuela) expressed his country's concern about the health situation in the occupied Palestinian territory and in the occupied Syrian Golan, which violated the human right to health, and urged other delegations to share that concern and to engage in bilateral cooperation, as the Bolivarian Republic of Venezuela had done. The Bolivarian Republic of Venezuela wished to be included in the list of sponsors of the draft resolution and demanded peace and justice for the Palestinian people.

Dr SUKAYRI (Jordan) said that the draft resolution reflected the situation on the ground in the occupied Palestinian territory, including east Jerusalem, and the occupied Syrian Golan. The practices and policies pursued by the Israeli occupation authorities had led to deteriorating health conditions. They included the imposition of a blockade and closures that prevented sick people from reaching hospitals and health care centres for treatment. He urged all Member States to support the draft resolution.

Dr SEITA (Director of Health, UNRWA) said that UNRWA provided health, education and other services for around five million Palestinian refugees in the West Bank, Gaza, Jordan, Lebanon and the Syrian Arab Republic, and reminded the Committee that almost half of the people living in the occupied Palestinian territory were refugees.

He expressed sincere appreciation of the continued support from host nations, international donors and stakeholders that enabled UNRWA to continue to work in the occupied Palestinian territory. That support had enabled it to improve the delivery of health services. A process of health reform had begun in late 2011 in response to the rapid increase in noncommunicable diseases. A person- and family-centred family health team approach had been introduced, together with e-health, and considerable progress had been made. However, the life of Palestinian refugees remained difficult if not desperate, and access to health as a fundamental human right had not been achieved. For example, levels of psychological trauma and post-traumatic stress disorder in the Gaza Strip had doubled since the fighting in November 2012. Of the patients treated by UNRWA for post-traumatic stress disorder, 42% were under the age of nine years. Of those patients referred for specialized care, 10% or more saw the requisite travel permit denied. That had to change, so that health could constitute a bridge to peace.

UNRWA would continue to pursue internal health reform in order to improve efficiency and continuity of care, but its efforts alone were not enough. He urged the international community to increase support to UNRWA so that, in collaboration with hosts, international donors and civil society, it could pursue the necessary health reforms and continue to protect and improve the health situation of Palestinian refugees.

Dr AL-NAYEF (Syrian Arab Republic) pointed out that the occupied Syrian Golan had been omitted from the third preambular paragraph of the draft resolution.

The CHAIRMAN, after consultation with the Legal Counsel, confirmed that the omission would be corrected. She recalled the request by Israel to proceed to a roll-call vote on the draft resolution.

At the invitation of the CHAIRMAN, Mr BURCI (Legal Counsel) explained the procedure for the roll-call vote. The Member States whose right to vote had been suspended by virtue of Article 7 of the Constitution, or which were not represented at the Health Assembly, and would therefore not participate in the vote were: Belize, Central African Republic, Comoros, Dominica, Grenada, Guinea-Bissau, Kyrgyzstan, Marshall Islands, Nauru, Niue, Palau, Saint Vincent and the Grenadines, and Somalia.

A vote was taken by roll-call, the names of the Member States being called in the English alphabetical order, starting with Fiji, the letter F having been determined by lot.

**The result of the vote was:**

**In favour:** Algeria, Angola, Azerbaijan, Bahrain, Bangladesh, Belarus, Bhutan, Bolivia (Plurinational State of), Brazil, Cambodia, Chile, China, Costa Rica, Cuba, Djibouti, Ecuador, Egypt, Guinea, India, Indonesia, Iran (Islamic Republic of), Iraq, Jordan, Kuwait, Lebanon, Libya, Malaysia, Maldives, Mauritania, Mexico, Morocco, Namibia, Nicaragua, Oman, Pakistan, Peru, Philippines, Qatar, Russian Federation, Saudi Arabia, South Africa, Sri Lanka, Sudan, Syrian Arab Republic, Tajikistan, Thailand, Tunisia, Turkey, United Arab Emirates, Uruguay, Venezuela (Bolivarian Republic of), Yemen, Zimbabwe.

**Against:** Australia, Canada, Israel, United States of America.

**Abstaining:** Andorra, Armenia, Austria, Bahamas, Belgium, Bulgaria, Cameroon, Colombia, Congo, Croatia, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Honduras, Hungary, Iceland, Ireland, Italy, Japan, Latvia, Lithuania, Luxembourg, Malta, Monaco, Netherlands, New Zealand, Nigeria, Norway, Papua New Guinea, Poland, Portugal, Republic of Korea, Republic of Moldova, Romania, Senegal, Singapore, Slovakia, Slovenia, Spain, Sweden, Switzerland, The former Yugoslav Republic of Macedonia, Ukraine, United Kingdom of Great Britain and Northern Ireland, Uzbekistan.

**Absent:** Afghanistan, Albania, Antigua and Barbuda, Argentina, Barbados, Benin, Bosnia and Herzegovina, Botswana, Brunei Darussalam, Burkina Faso, Burundi, Cape Verde, Chad, Cook Islands, Côte d'Ivoire, Democratic People's Republic of Korea, Democratic Republic of the Congo, Dominican Republic, El Salvador, Equatorial Guinea, Eritrea, Ethiopia, Fiji, Gabon, Gambia, Georgia, Ghana, Guatemala, Guyana, Haiti, Jamaica, Kazakhstan, Kenya, Kiribati, Lao People's Democratic Republic, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritius, Micronesia (Federated States of), Mongolia, Montenegro, Mozambique, Myanmar, Nepal, Niger, Panama, Paraguay, Rwanda, Saint Kitts and Nevis, Saint Lucia, Samoa, San Marino, Sao Tome and Principe, Serbia, Seychelles, Sierra Leone, Solomon Islands, South Sudan,

Suriname, Swaziland, Timor-Leste, Togo, Tonga, Trinidad and Tobago, Turkmenistan, Tuvalu, Uganda, United Republic of Tanzania, Vanuatu, Viet Nam, Zambia.

**The draft resolution, as amended, was therefore approved by 53 votes to 4, with 50 abstentions.<sup>1</sup>**

Mr BAGHERPOUR (Islamic Republic of Iran), speaking in explanation of vote, said that although his country had supported the draft resolution, it had reservations concerning those parts of it, and of the report contained in document A66/28, that might be construed as recognition of the Israeli regime.

Professor LEE (Singapore), speaking in explanation of vote, said that her country's abstention was not intended as a statement on the merits or demerits of the issue; indeed, Singapore had consistently supported the rights of Palestinians to a homeland, a two-State solution and all efforts to bring about a just and lasting peace in the region. Nevertheless, it was not appropriate to introduce political elements into a Health Assembly resolution, irrespective of the difficult health situation faced by Palestinians.

Mr CORR (Ireland), speaking in explanation of vote and on behalf of the European Union and its Member States, said that Croatia aligned itself with his statement. The European Union remained very concerned about the health situation in the occupied Palestinian territory and east Jerusalem but considered that the draft resolution contained elements relating to political matters that were outside the remit of the Health Assembly. It appreciated the efforts by the Palestinian delegation to reach out for a common agreement on the wording of the text and, although the European Union had not voted in favour of the resolution, it remained committed in future dialogue to improving the substantive issue of the health and living conditions of the Palestinian people.

Since 1971, the European Union had been the largest provider of development aid to the occupied Palestinian territory, contributing some €4 billion between 2000 and 2012 and almost 40% of total support in 2011 and 2012, always targeting the four most important areas: health, education, humanitarian needs and shelter. The European Union was also a reliable donor: since 2011, it had been firmly committed to UNRWA's support for the health sector, and since 2008 it had allocated €150 million in direct financial support for the salaries of Ministry of Health employees. Exceptionally, the European Union had earmarked €10 million for hospitals in east Jerusalem to respond to the financial crisis faced in Palestine in 2012, and a further €13 million was expected to be provided in 2013. In addition, it had funded smaller civil society and nongovernmental projects for the implementation of a number of humanitarian projects in the health sector.

The European Union remained committed to assisting Palestinians in realizing their right to appropriate health care, including adequate emergency services. It would continue to play an active role in efforts to improve health conditions in the occupied Palestinian territory and to address the humanitarian needs of the Palestinian people. It was important to find an approach that adequately took into consideration the impact of the conflict on all sides.

Ms STONE (Australia), speaking in explanation of vote, said that her country had decided to oppose the draft resolution on the grounds that the agenda item could introduce unnecessary political issues into the forum, but that position in no way reflected a lack of concern. Australia gave its full support to negotiations for a comprehensive and enduring peace based on a two-State solution and called on Israel and Palestine, partner countries and agencies to work together to alleviate the poor health conditions in the West Bank and the Gaza Strip. However, the draft resolution contributed neither to a negotiated solution to the conflict nor to improving the situation on the ground. In 2012,

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<sup>1</sup> Transmitted to the Health Assembly in the Committee's first report and adopted as resolution WHA66.5.



her country had made substantial contributions in support of the peace process, helping to develop Palestinian institutions and improve basic services, including in the health sector.

Mr ESCOBEDO (Guatemala) said that his delegation had not been present during the voting but he wished it to be recorded that Guatemala also supported the draft resolution.

The CHAIRMAN indicated that the Legal Counsel had advised her that, under the Rules of Procedure of the World Health Assembly, the record of the vote could not be changed, but that the statement of the delegate of Guatemala could be included in the official record of the current meeting.

**It was so agreed.**

Mr REAICH (New Zealand), speaking in explanation of vote, said that although his delegation recognized that the language in the draft resolution was more balanced than that of the draft resolution considered by the Committee at the Sixty-fifth World Health Assembly, it had decided to abstain. Had the text been limited to addressing humanitarian needs and had it not engaged in political issues outside the mandate of the Health Assembly, his delegation would have supported it. He urged relevant governments to ease access restrictions imposed on humanitarian goods and people, and to cooperate to ensure lasting improvements of the health status of the Palestinian people.

Mr ZUHAIRI (Palestine), speaking in exercise of the right of reply in accordance with Rule 57 of the Rules of Procedure of the World Health Assembly, thanked all those who had voted in favour of the resolution. While he fully understood the position of Member States who had voted against it, he was unable to understand the position of those who had abstained. With regard to the allegations of politicization that he had heard from some speakers, he defied anyone to identify a political element in the resolution. His delegation had stated repeatedly that it was willing to delete all political elements. It had made clear from the outset that the aim was to request Israel to comply with its legal obligations as a Member State of the Organization. For reasons he did not wish to mention, some Member States felt that an abstention would be acceptable to Israel, but they also knew full well that it would encourage the political authorities and security forces in Israel to proceed with and step up their violations. As he had already stated, the Palestinian authorities were seeking to cooperate with the Israeli Ministry of Health and to implement the agreement between Magen David Adom and the Palestinian Red Crescent Society, but the political authorities and the security forces were obstructing progress on both fronts.

As for politicization, it had actually stemmed from those seeking amendments to the draft resolution. The sponsors had been asked to delete the words “occupying power” from the text. They would in fact be happy if Israel were no longer an occupying power but a State that existed side by side with the State of Palestine. The sponsors had also been asked to take into account Israeli security needs in the territory of the State of Palestine. He wondered how that might be achieved. A further request was to delete all references to the occupied Syrian Golan, because of the current hostilities in the Syrian Arab Republic. He pointed out, however, that, regardless of those events, the Golan remained occupied Syrian territory. A clear line must be drawn between the two situations.

Palestine greatly appreciated all support, but it was essential to understand its position. The Palestinian people had been expelled without warning from their homes in Palestine. They required help to bring that situation to an end.

(For continuation of the discussion, see the summary record of the second meeting, section 2.)

**4. FINANCIAL MATTERS:** Item 21 of the Agenda

**Financial report and audited financial statements for the period 1 January 2012–31 December 2012:**  
Item 21.1 of the Agenda (Documents A66/29, A66/29 Add.1 and A66/54)

Dr THABET NASHER (Yemen), speaking in his capacity as Chairman of the Programme, Budget and Administration Committee of the Executive Board, drew attention to the Committee's report of its discussions on the item, which was contained in document A66/54. The Committee had recommended, on behalf of the Executive Board, that the Health Assembly adopt the draft resolution contained in document A66/54.

Ms HERNÁNDEZ NARVÁEZ (Mexico) recognized the full adoption of the International Public Sector Accounting Standards (IPSAS) for auditing as a key step in the reform of the United Nations system, including WHO. It was not merely an accountancy manoeuvre but involved a change in the working culture of the Organization and could help to enhance accountability, transparency and governance. As noted by the Independent Expert Oversight Advisory Committee, the financial accounts now showed all of the Organization's assets and unfunded liabilities, and therefore depicted the true financial situation.

The DIRECTOR-GENERAL commended the efforts made by WHO staff to ensure, with few additional resources, that the financial reports were IPSAS-compliant; she hoped that similar efficiency gains could be made in other areas. Savings on travel had been disappointingly low despite the fact that WHO personnel were travelling less and at lower classes of ticket, but that could be due in part to the rising prices of air tickets. The Secretariat would use the Global Management System to look in detail at further ways to cut costs and then decide where to focus its cost-saving efforts. Despite the success of introducing IPSAS compliance in the reporting, there was room for improvement in a number of other areas highlighted in the audit reports and the report of the Independent Expert Oversight Advisory Committee.

She expressed concern at the large actuarial valuation of staff health insurance. A special committee had been set up to find ways to mitigate the risk of exposure to that liability. The Secretariat was prepared to carry out further measures in the medium and long term to address the situation and was open to any further creative ideas; after all, it was the collective responsibility of all interested parties to find solutions to the problem. Input by participants at the recent meeting of the Programme, Budget and Administration Committee had been useful, and WHO was constantly learning from other organizations how it could reduce its liability without compromising staff benefits.

She also emphasized that never before had she seen such a promising level of constructive engagement among Member States; that engagement would certainly help to make WHO successful.

The CHAIRMAN invited the Committee to approve the draft resolution contained in document A66/54.

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

**The meeting rose at 17:15.**

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<sup>1</sup> Transmitted to the Health Assembly in the Committee's first report and adopted as resolution WHA66.6.

## **SECOND MEETING**

**Thursday, 23 May 2013, at 09:10**

**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)

### **1. FIRST REPORT OF COMMITTEE B: (Document A66/66)**

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

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

### **2. HEALTH CONDITIONS IN THE OCCUPIED PALESTINIAN TERRITORY, INCLUDING EAST JERUSALEM, AND IN THE OCCUPIED SYRIAN GOLAN: Item 20 of the Agenda (Documents A66/28, A66/INF./1, A66/INF./2, A66/INF./3 and A66/INF./4) (continued from the first meeting, section 3)**

Mr SIDIKOV (Uzbekistan) said that during the roll-call vote on the draft resolution on the health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan considered at the Committee's first meeting, which had resulted in its approval, his delegation had mistakenly declared that it wished to abstain, rather than not taking part. He asked for the official record to be amended so as to indicate that Uzbekistan had in fact not taken part in the vote.

Mr MERCADO (Argentina) said that his delegation had been unable to be present for the vote on the draft resolution. Had his delegation been present, it would have voted in favour of the text.

Mrs SY (Senegal) said that her delegation had also been unable to be present for the vote on the draft resolution. Had her delegation been present, it would have voted in favour of the text, rather than abstaining as had been recorded.

Ms MOURAIN-SCHUT (Office of the Legal Counsel) explained that under the Rules of Procedure of the World Health Assembly, the record of the vote could not be changed, but that the statements of the three delegates would be reflected in the official record of the current meeting.

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<sup>1</sup> See page 311.

**3. MANAGEMENT AND LEGAL MATTERS:** Item 24 of the Agenda**Reassignment of South Sudan from the Eastern Mediterranean Region to the African Region:**  
Item 24.4 of the Agenda (Documents A66/43 and A66/43 Add.1)

The CHAIRMAN drew the attention of the Committee to the draft resolution contained in document A66/43. The financial and administrative implications for the Secretariat were set out in document A66/43 Add.1.

Dr DIAKHABY (Guinea), speaking on behalf of the Member States of the African Region, and Mr ELIAS (Ethiopia) expressed their support for the draft resolution, which had been approved by the Regional Committee for the Eastern Mediterranean and the Regional Committee for Africa.

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

Dr HUSSEIN (South Sudan) thanked the Committee for approving his country's request for reassignment to the African Region, the sole reason for which was the similarity in disease patterns and epidemiology between South Sudan and the other countries of the Region. Other United Nations system agencies had similarly agreed a reassignment. His Government greatly appreciated the support it had received from the Eastern Mediterranean Region since independence, and now pledged to cooperate fully with the African Region.

**4. FINANCIAL MATTERS:** Item 21 of the Agenda (continued)**Status of collection of assessed contributions, including Member States in arrears in the payment of their contributions to an extent that would justify invoking Article 7 of the Constitution:**  
Item 21.2 of the Agenda (Documents A66/30 and A66/55)

The CHAIRMAN said that, at its recent meeting, the Programme, Budget and Administration Committee of the Executive Board had considered the draft resolution on status of collections contained in the Secretariat report (document A66/30) and had amended the text to take into account recent contribution payments. The amended text was contained in the report on the item by the Committee, which was set out in document A66/55.

Mr JEFFREYS (Comptroller) reported that a payment had recently been made by Djibouti, which was thus no longer subject to the provisions of Article 7 of the Constitution. The references to Djibouti could therefore be deleted from the draft resolution.

**It was so agreed.**

Mrs LARUE (Seychelles), speaking on behalf of the Member States of the African Region, said that while the overriding majority of the Region's 46 Member States had met their financial obligations, unfortunately three of them were in arrears to a serious degree and two more to a lesser degree.

Article 7 of the WHO Constitution, by its use of the word "may", did not make the suspension of voting privileges and services automatic, thereby giving the Health Assembly significant discretion to act. Some countries in the Region were facing enormous social problems, even civil war, which

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<sup>1</sup> Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA66.21.

made it difficult for them to pay their full contribution. Yet those same countries needed a strong voice in WHO, and its support, as never before. The African Region urged the Health Assembly to restore voting privileges and services to the African countries concerned and not to suspend the voting privileges of any others that were able to demonstrate that they were experiencing difficulties.

Mr QASEM (Jordan) said that Jordan regularly paid its assessed contributions to the Organization. Under existing regulations in his country, however, the Ministry of Finance, which was responsible for such payments, could not disburse the funds until it had received a request for payment and, apparently, no request had been received. It was, however, taking steps to pay at least part of its assessed contribution.

Ms CHERQAOU (Morocco) said that her country's contribution for 2012–2013 had been approved and the arrangement for payment was moving through the administrative channels. She suggested that invoices for contributions be dispatched earlier, to give countries time to make payment preparations.

Ms BEN MARZOUK (Tunisia) said that her country had also made its payment, and requested that the corresponding list be corrected.

Mr JEFFREYS (Comptroller) pointed out that Annex 1 to document A66/30 presented the status of collection of assessed contributions as at 31 December 2012. That situation was constantly evolving as countries sent in their payments. As he understood it, all invoices had been dispatched; invoices were also available on the WHO web site, and he could provide copies of them on request.

The draft resolution before the Committee referred both to Article 7 and to the statement of principles set out in resolution WHA41.7, which had been adopted in order to clarify that suspension of voting privileges was distinct from suspension of services. There had never been any suggestion, nor would there ever be, that services to Member States would be discontinued because they were in arrears.

The word “may” did indeed mean that the suspension of voting privileges was not automatic. Nevertheless, the Health Assembly had in the past usually suspended the privileges of all Member States to which Article 7 applied in order to reinforce the principle that each Member State should make every possible effort to pay its assessment in full. Any Member State experiencing financial difficulties was invited to submit a plan for rescheduling its arrears over an extended period, as Tajikistan had recently done. That facility had reduced significantly the number of Member States in default.

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

**Special arrangements for settlement of arrears:** Item 21.3 of the Agenda (Documents A66/45 and A66/55)

The CHAIRMAN invited the Committee to consider the draft resolution contained in document A66/45, concerning the special arrangements for the settlement of arrears by Tajikistan.

Mr KORA-BATA (Benin), speaking on behalf of the Member States of the African Region, expressed support for the draft resolution contained in document A66/45, which recognized Tajikistan's efforts to achieve financial compliance progressively despite the effects of the global economic crisis.

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<sup>1</sup> Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA66.13.

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

Mr RAHMONOV (Tajikistan) thanked the Committee for the favourable consideration it had given to his country's request.

**Scale of assessments for 2014–2015:** Item 21.4 of the Agenda (Documents A66/31 and EB132/2013/REC/1, resolution EB132.R6)

The CHAIRMAN drew attention to the draft resolution contained in resolution EB132.R6.

Mr SEN (Turkey) observed that assessed contributions were the most important and, at the same time, the most flexible part of WHO's funding. He wished it to be noted that in the past four years Turkey had seen its assessment increased four times.

Mr LI Mingzhu (China) expressed support for the draft resolution, while pointing out that the proposed new scale of assessments increased China's contribution significantly. China would meet its new financial obligations, but at the same time appealed to those Member States whose assessed contribution had decreased to consider providing the corresponding amount in the form of voluntary contributions.

**The draft resolution was approved.<sup>2</sup>**

**Scale of assessments for 2014–2015: foreign exchange risk management:** Item 21.4 of the Agenda (Documents A66/32 and A66/56)

Dr THABET NASHER (Yemen), speaking in his capacity as Chairman of the Programme, Budget and Administration Committee of the Executive Board, introduced the Committee's report on foreign exchange risk management, contained in document A66/56. The Committee, on behalf of the Executive Board, had recommended the adoption of the draft resolution contained in document A66/32.

**The draft resolution was approved.<sup>3</sup>**

## **5. AUDIT AND OVERSIGHT MATTERS:** Item 22 of the Agenda

**Report of the External Auditor:** Item 22.1 of the Agenda (Documents A66/34 and A66/58)

Dr THABET NASHER (Yemen), speaking in his capacity as Chairman of the Programme, Budget and Administration Committee of the Executive Board, introduced the Committee's report on the item, which was contained in document A66/58. The Committee, on behalf of the Executive Board, had recommended the adoption of the draft resolution contained in its report.

Ms TAN (representative of the External Auditor), speaking on behalf of the External Auditor, introduced the report of the External Auditor (document A66/34). The External Auditor had issued an

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<sup>1</sup> Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA66.14.

<sup>2</sup> Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA66.15.

<sup>3</sup> Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA66.16.

unqualified audit opinion on the financial statements for the financial period 2011–2012, which were based for the first time on the International Public Sector Accounting Standards (IPSAS), but had made a series of recommendations in various areas. In future, the External Auditor would strive to link its audit even more closely to the Organization's accountability needs and management reforms; it would also pursue its efforts to support WHO in managing its business risks in order to create more value for the Organization.

Mr MONTEIRO (Cape Verde), speaking on behalf of the Member States of the African Region, commended the report of the External Auditor. In the course of the audits conducted in 2012, with particular emphasis on compliance with IPSAS, the External Auditor had brought to light the need for certain adjustments, which had already been made by the Organization. WHO should implement the additional recommendations made by the External Auditor with a view to improving the Organization's financial management and governance capacities.

Dr SINGH (India) endorsed the External Auditor's recommendation that yearly expenditure should be compared with annual rather than biennial budgets and that budget and expenditure figures should be presented in a way that would facilitate comparison between them.

Noting with concern that the effectiveness of the Global Service Centre in providing services under the Global Management System had been impaired by the poor quality of inputs, failure to use manual controls, and an absence of system control in some processes of the Global Management System, she called on the Secretariat to eliminate the system of manual approvals that paralleled automatic approvals in the Global Management System. She also encouraged the Secretariat to develop and implement as rapidly as possible a global inventory management system, and in view of the importance of human resources, an Organization-wide human resources policy.

The External Auditor's report referred to medicines valued at US\$ 13 million with an expiration date of 2011 but still stored in WHO warehouses: what proportion of the total medicines procured and distributed during the period covered by the report did that represent?

India strongly endorsed the External Auditor's request that the Secretariat should ensure proper implementation of audit recommendations that had not yet been acted upon.

Ms BLACKWOOD (United States of America), welcoming the External Auditor's many constructive recommendations, encouraged the Secretariat to sustain the momentum in the area of risk management and to establish a schedule for the development of risk registers, as well as an action plan for deploying the risk management structure throughout the Organization. Some of the recommendations made by the External Auditor highlighted weaknesses in WHO's internal control framework; concerted efforts at all levels of the Organization were needed to tackle those problems.

Mr COTTERELL (Australia) urged the Secretariat to accept and implement all the recommendations put forward in the External Auditor's report, as well as prior audit recommendations. Management should continue to spearhead the efforts to move the Organization's culture towards a results-based management approach, which, in the case of the Western Pacific Region, meant setting up better procedures for reporting to donors.

Audit practices and fraud had been highlighted as a priority for WHO in an assessment of multilateral agencies conducted by Australia's development assistance agency, AusAID, in 2012. Further improvements in that area would be welcome, as part of the broader WHO reform process.

Mr SEN (Turkey) said that the External Auditor's report provided insight into the Organization's strengths and weaknesses. The fact that recommendations made in previous audit reports were being or had been implemented was encouraging, but with respect to the current report, further detailed information was needed about the strategy for implementing the recommendations, the scope of the corrective action to be taken, and the schedule to be followed. Without such information it would not be possible to measure progress.

Mr RODRÍGUEZ NICOLAT (Mexico) said that because the transition to IPSAS required a great deal of effort on the part of WHO and Member States, it would be useful if the External Auditor could maintain regular contact with both the Secretariat and the Independent Expert Oversight Advisory Committee in the interests of avoiding duplication of efforts and making the best use of the information available.

Dr AROONA (Maldives) supported the External Auditor's recommendation that yearly expenditure should be compared with annual rather than biennial budgets. As a small country without economies of scale, her country had encountered difficulties in the area of medicine procurement, with shortages alternating with provision of medicines past their expiry date. She hoped that the External Auditor's recommendations would help to improve the Organization's future management of its funds.

Ms TAN (representative of the External Auditor), speaking on behalf of the External Auditor, thanked delegates for their encouraging words. The Commission on Audit of the Republic of the Philippines, elected as the External Auditor of WHO for the financial period 2012–2015, would continue to work to ensure the interest of all stakeholders in the Organization.

Dr JAMA (Assistant Director-General) said that the Director-General had accepted all the recommendations of the External Auditor, the Internal Auditor and the Independent Expert Oversight Advisory Committee. He assured the delegate of Turkey that the improvements under way were being carefully monitored and reported on both within the Secretariat and with respect to the Member States, through the Programme, Budget and Administration Committee and directly, as was the case at the present meeting. A document on Organization-wide risk management, which included a section on risk registers, would be considered by the Executive Board at its 133rd session immediately following the current Health Assembly. That topic was being taken very seriously across the Organization.

The Secretariat was also preparing a training programme on the internal control framework, including risk management and delegation of authority. The intention was to clarify the role of managers, who would henceforth be held accountable for each decision they made, under the WHO accountability framework.

In the interests of greater effectiveness at country level, and in particular, in order to mitigate the weaknesses identified by the External Auditor, he urged Member States to cooperate in the area of direct financial cooperation. Member States needed to improve their reporting on resources used, and the Secretariat needed to strengthen its monitoring in that regard.

The Global Management System already featured built-in controls. An upgraded version would be launched on 5 June 2013, but that would not suffice to overcome its shortcomings: what was also needed was a change in culture, to be achieved through advocacy and training.

The DIRECTOR-GENERAL thanked the External Auditor for an excellent report, and confirmed that she had accepted all of its recommendations. She herself, and the regional directors, took audits very seriously, studying them in detail and ensuring the implementation of their recommendations. She had also taken note of the concerns of the Independent Expert Oversight Advisory Committee. Audit reports were vital to senior management as a source of detailed information on aspects of the Organization's operations that were, or were not, working properly.

The first step in strengthening internal controls was to create a culture of transparency and accountability. The Organization's rules, whether in the area of finance, human resources or elsewhere, must be respected, and individual officers' responsibilities met. Training was important, and staff moving from specialized technical areas into management functions were required to take training courses in management techniques.

The consequences for good or bad performance would change. Incentives would be awarded to staff who were fulfilling their duties conscientiously and exercising proper internal controls. At the same time, staff who delayed carrying out their work or tried to circumvent the rules would bear the repercussions, which might go as far as dismissal. She had zero tolerance for such irregularities, and



wished to assure Member States publicly of her resolve in that regard. Such changes were part of the WHO reform process.

In respect of direct financial cooperation, WHO could not do its work properly if the Member States involved did not provide reports in a timely manner. Provision of information to headquarters had to be a joint effort between the WHO regional office and the country concerned. Regional staff sometimes found it difficult to be forceful in pursuing the reports needed from health ministries, while national government staff might find such diligence annoying, but it was what she needed and expected. Countries receiving financial support from the Organization should submit timely reports and evidence to demonstrate how they were using the funds received. She would prefer to continue direct financial cooperation, but if the situation did not improve in two years' time, she would consider closing the mechanism down. Collectively, the WHO Secretariat and the Member States had a duty of accountability to the citizens of the world, who provided the funds to finance the Organization's operations.

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

**Report of the Internal Auditor:** Item 22.2 of the Agenda (Documents A66/35 and A66/59)

Dr THABET NASHER (Yemen), speaking in his capacity as Chairman of the Programme, Budget and Administration Committee of the Executive Board, introduced the Committee's report on the item, which was contained in document A66/59. The Committee, on behalf of the Board, had recommended that the Health Assembly should note the report of the Internal Auditor (document A66/35).

Mr STUPPEL (United Kingdom of Great Britain and Northern Ireland) said that Member States needed to ensure the Organization's accountability and transparency, and welcomed the move towards compliance with IPSAS. However, there were still outstanding audits without specific deadlines and, in that regard, efforts should be made to strengthen audit controls and create greater awareness of fraud risks. The establishment of the new Compliance, Risk Management and Ethics Office should enhance the auditing process and foster transparency.

Mr KÜMMEL (Germany) said that monitoring the implementation of individual recommendations, which had been the Organization's strategy in the past, was not sufficient since there had been recurrent patterns of unacceptable levels of risk and major weaknesses in the internal control framework. Effective measures were needed to counter those deficits and the "meta-analysis" conducted by the Internal Auditor was an excellent starting point.

The significant increase in the Organization's financial resources over the past 20 years had had a considerable impact on the audit operations of the Office of Internal Oversight Services. Yet, the number of auditors had remained at eight for the past 15 years. That was perhaps not enough to cope with the increased size of the Organization's undertakings.

The firm message just given by the Director-General and the plan by senior management to conduct a holistic review of the changes needed to eliminate recurrent weaknesses and non-compliance were steps in the right direction. Such actions were essential to the overall reform of the Organization.

Mr COTTERELL (Australia) endorsed the statement made by the delegate of Germany. Unimplemented recommendations and the lack of effective controls were matters for concern, and practical measures were needed to address them.

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<sup>1</sup> Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA66.17.

Mr LI Mingzhu (China) said that he shared the concerns of the Programme, Budget and Administration Committee, especially with regard to residual risk, and urged the Secretariat to continue its efforts to improve the situation. Further information in respect of the Secretariat's commitment to apply the Internal Auditor's recommendations on staff evaluation would be appreciated. Staff training and incentives, and a culture of compliance with the rules of the Organization, should be reinforced.

Mr JONES (Canada) encouraged the Organization to continue strengthening controls, particularly in the area of procurement, and to explore opportunities for expanding the capacity of the Office of Internal Oversight Services.

Dr SINGH (India) welcomed the steps that had been taken to improve compliance, implement audit recommendations in a timely and efficient manner, and prevent shortcomings in areas subject to audit. The inadequacy of controls, in particular with regard to procurement procedures in country offices, was a matter of concern and should be reviewed.

Mr WEBB (Office of Internal Oversight Services), thanking delegates for their encouraging comments, assured the Committee that there had been progress in the follow-up of recommendations, particularly those pertaining to areas of highest risk, as reflected in the number of audits closed in the previous year and in the greater number of items that had been addressed. A plan was in place to upgrade the capacity of the Office of Internal Oversight Services: the current phase would increase technical capacity, and the next phase, scheduled for the period 2014–2015, would strengthen evaluation capacity. A sound risk-assessment model was in place to ensure that audit resources were allocated to the areas of highest risk, the criteria for which were discussed annually with the Independent Expert Oversight Advisory Committee, and modern approaches were being adopted to increase efficiency. Within the past two years, recommendations had been made to the Global Policy Group on action to be taken at the highest level on systemic issues, including resource management, the Global Management System and strengthening the internal control framework.

Dr JAMA (Assistant Director-General) said that progress in the implementation of audit recommendations, which was summarized in the Report of the Internal Auditor, was being carefully evaluated, as were the reasons for the recurring systemic issues, in particular in WHO country offices. The upgrading of the Global Management System would make it possible to monitor electronically, through a dashboard, the most important areas – including travel, human resources and procurement – at the country and individual level. With regard to staff evaluation, the responsibilities, functions and post descriptions of managers – as well as the delegation of authority tables for regional directors, assistant directors-general, directors of programme management, directors of administration and finance, WHO Representatives and other senior managers – were being reviewed with a view to defining a clear set of responsibilities and incentives for all managerial posts. A review would also be conducted of performance management for individual staff, in particular with regard to the deployment of human and financial resources. In addition, staff training would be increased and adherence to rules enforced.

**The Committee noted the report.**

## 6. STAFFING MATTERS: Item 23 of the Agenda

### Human resources: annual report: Item 23.1 of the Agenda (Documents A66/36 and A66/60)

Dr THABET NASHER (Yemen), speaking in his capacity as Chairman of the Programme, Budget and Administration Committee, introduced the Committee's report on the item, which was contained in document A66/60. The Committee, on behalf of the Executive Board, had recommended that the Health Assembly should note the Secretariat's report (document A66/36).

Mr KÜMMEL (Germany) welcomed the Secretariat's report but urged timely distribution in future to permit detailed analysis. He expressed full support for the target of gender parity in WHO. The Secretariat's report called for gender parity to be achieved within the next decade, but many Member States had repeatedly called for immediate action. He requested information on the measures needed to attain the target. He endorsed the Director-General's commitment to strengthening the Organization's performance at country level in a fully transparent manner as a key part of the reform process. In that spirit, WHO country presence reports should be made available to the governing bodies to enable them to provide guidance in that area.

Mr XABA (Swaziland), speaking on behalf of the Member States of the African Region, said that the Organization depended on highly skilled and motivated staff for its survival. He endorsed the Secretariat's report and acknowledged the efforts made to improve staff development and well-being. However, it was a matter of concern that women were still underrepresented in the professional and higher categories; that the 50% target set in 1997 had not been reached; and that geographical distribution of staff remained skewed towards developed countries. Furthermore, it was unacceptable that some countries in the African Region and the Region of the Americas were not represented at all. The recruitment process should be made easier and more transparent to promote an injection of innovative approaches into the Organization.

Mr KOLKER (United States of America) highlighted the long-term liabilities for the Organization arising from the routine conversion of fixed-term contracts to continuing appointments for the staff of the Global Polio Eradication Initiative, which would, he hoped, end in 2018, and endorsed the recommendation by the Programme, Budget and Administration Committee that the subject should form a separate section in future human resources reports. The progress made in human resources reform had been satisfactory but the Secretariat should develop more options for career progression and recruitment from outside WHO, based on the four pillars of human resources reform. He too supported the emphasis on WHO country offices and hoped that it would result in increased implementation of the best practices developed at headquarters.

Mr STUPPEL (United Kingdom of Great Britain and Northern Ireland) said that, given that staff and non-staff contractual services comprised almost 60% of WHO expenditure, it was essential for the Organization to have an effective human resources system. In that connection, the Secretariat should in future ensure that the human resources report was available early enough for Member States to have adequate time to examine it. In terms of human resources reform, particular importance should be placed on improving the gender balance at WHO, increasing staff mobility and flexibility, aligning skills with posts, and maintaining efficient performance management systems.

Mr LI Mingzhu (China) said that the information given in the annual report on human resources should help Member States to provide more precise guidance on staffing matters. The low level of representation of developing countries over the previous decade remained a matter of concern and action should be taken to improve the situation. According to the report, more than 50% of long-term staff were currently assigned to country offices, but that did not necessarily indicate a more strategic

deployment of human resources. WHO should focus on recruiting staff that could bolster its leadership role, in particular in terms of strategy.

Dr SHOHANI (Iraq) said that the Secretariat's report had neglected to mention the allocation of financial resources to capacity-building. The development of human resources was of vital importance, but such efforts must be tailored to country needs and priorities. Local officials should be given the opportunity to work at WHO country and regional offices; that would improve performance at the offices and at the same time familiarize the officials with international standards.

Dr IWATA (Japan) welcomed the significant rise in the assignment of long-term staff to country offices over the past decade. The issue of gender imbalance must be addressed urgently: the percentage of women in professional posts had increased very little in the previous four years and the target for women in professional and higher categories had still not been met. The Organization's current financial constraints had led to a decrease in vacant posts, making it all the more important to recruit the best candidate for the posts that remained. It might also be useful to modify recruitment procedures to give external and internal candidates an equal chance.

Mr SANDRASAGREN (Human Resources Management) said that the current report was the first to be published in the new format, which reflected changes proposed by Member States. Approximately half the Organization's posts were located in the African, South-East Asia and Eastern Mediterranean Regions, yet only 29% of the applicants for those posts were women; efforts were being made to identify solutions to that problem. WHO was also continuing efforts in line with the United Nations system-wide action plan to achieve gender parity. An implementation plan had been submitted and would be followed up with specific activities. A capacity-building strategy to raise staff awareness of gender parity would also be implemented. Other measures included a focus on flexible working arrangements and work-life balance, and the inclusion on recruitment short lists of at least one female candidate. For the purposes of recruitment, geographical distribution was always taken into account, and internal and external candidates were given equal consideration through a rigorous competitive process.

Dr JAMA (Assistant Director-General) said that the Secretariat would be monitoring recruitment in order to ensure that non-staff contractual services did not replace staff functions in the Organization. In terms of the long-term liability with regard to the staff of the Global Polio Eradication Initiative, which would be phased out in 2018, WHO was working to identify short- and long-term solutions for the more than 900 staff members concerned. It was important for WHO to develop policies governing programmes of limited duration, and the study that had been commissioned by the Programme, Budget and Administration Committee would undoubtedly provide some solutions in that regard.

In reply to the delegate of Germany, he said that distribution of WHO country presence reports had been restricted to date but that, starting with the 2012 report, they could be made available to Member States. Some of the information in those reports, for example, the distribution of general service and professional staff by programme area and geographical location, and the total number of staff in each country and region, would also be contained in the document on the financing dialogue that would be submitted to Member States. Currently, 3800 WHO staff members out of a total of 7338 were in the general service category, and the majority were assigned to regional offices; that situation was due in part to budget constraints in the regions, where skilled individuals were sometimes recruited as general service category staff. The Secretariat would welcome further guidance on the four pillars of human resources reform outlined in its report.

The DIRECTOR-GENERAL said that its staff were the Organization's greatest asset and she intended to preserve that by modifying WHO's human resources policy. First, an active search would be made for female candidates and, during the recruitment process, both the selection panel and the

shortlist for each post to be filled would have to include at least one suitably qualified woman. Second, efforts would be made to redress the imbalance between staff from developed and developing countries. That was a sensitive subject since the developing countries themselves wished to keep their highly skilled professionals and were sometimes irritated when such individuals were recruited by WHO; it was therefore up to the Organization to engage those countries in a dialogue on the subject. Another obstacle was the failure of some competent candidates from developing countries to perform well during recruitment interviews. WHO had therefore been cooperating with the authorities in developing countries to provide training in interview techniques and related matters.

The Organization's career structure should be reviewed and ways identified of encouraging the recruitment of young people. WHO currently recruited mainly at senior and managerial level, limiting career development opportunities within the Organization. Junior-level staff members should also be given the chance to gain experience in various areas of the Organization to allow them afterwards to specialize and move forward in their career. Recruiting experienced professionals post-retirement was another possibility: retirees could be employed under short-term contracts to provide technical expertise in specialized areas and to serve as a model for younger staff.

Staff rotation and mobility should be encouraged since it gave rise to greater creativity and a broader range of ideas. Core staff, for whom rotation was not an option, also played an important role by helping to preserve and transmit the Organization's institutional memory.

Mr DIKMEN (Turkey) said that according to the most recent financial statements, there was a significant liability in respect of health insurance for WHO staff. That funding burden should be taken into consideration in any future human resources planning.

**The Committee noted the report.**

**Dr Singh took the Chair.**

**Report of the International Civil Service Commission:** Item 23.2 of the Agenda (Documents A66/37 and A66/61)

The CHAIRMAN said that, as indicated in its report on the item (document A66/61), the Programme, Budget and Administration Committee, on behalf of the Executive Board, had recommended that the Health Assembly note the report (document A66/37).

Mr RODRÍGUEZ NICOLAT (Mexico) welcomed the review of the remuneration for staff in the professional and higher categories and recalled that the United Nations General Assembly had asked the Commission, in undertaking the review, to bear in mind the financial situation of the organizations of participating in the United Nations common system and their capacity to attract a competitive workforce. He requested the Director-General to provide the necessary information to the Commission and to keep the Programme, Budget and Administration Committee and Member States informed about progress.

Dr JAMA (Assistant Director-General) said that the United Nations would be launching a system-wide study on the compensation package, which would be completed towards the end of 2014, at which time the findings would be made available.

**The Committee noted the report.**

**Amendments to the Staff Regulations and Staff Rules:** Item 23.3 of the Agenda (Documents A66/38 and EB132/2013/REC/1, resolution EB132.R11)

The CHAIRMAN invited the Committee to consider the action recommended in the Director-General's report (document A66/38), which related to resolution EB132.R11. If she heard no objections, she would take it that the Committee wished to approve confirmation that the salaries of staff in ungraded posts and of the Director-General remained unchanged.

**It was so agreed.**

**Report of the United Nations Joint Staff Pension Board:** Item 23.4 of the Agenda (Document A66/39)

Mr ELIAS (Ethiopia), speaking on behalf of the Member States of the African Region, said that the return on the investments made by the United Nations Joint Staff Pension Fund was being adversely affected by the current volatile financial market. The Fund's investment management arm should be strengthened in order to cope more effectively with the vagaries of the situation. He suggested that any action taken with regard to staff benefits should be aligned with the WHO reform process. The finding with respect to disability and death benefit awards that psychiatric conditions were the leading cause of disability within the Organization merited investigation and, if necessary, appropriate action.

Mr SANDRASAGREN (Human Resources Management) said that the Fund had recommended that the retirement age should be raised to 65 years to ensure its actuarial sustainability. The concerns raised by the delegate of Ethiopia would be transmitted to the Pension Board.

**The Committee noted the report.**

**Mrs Tyson resumed the Chair.**

**Appointment of representatives to the WHO Staff Pension Committee:** Item 23.5 of the Agenda (Document A66/40)

The CHAIRMAN proposed the nomination of Dr Viroj Tangcharoensathien (Thailand) as a member of the WHO Staff Pension Committee for a three-year term until May 2016, and Mrs Palanitina Tupuimatagi Toelupe (Samoa) as a member of the WHO Staff Pension Committee for the remainder of her term of office until May 2014. She further proposed the nomination of Dr Mahmoud N. Fikry (United Arab Emirates) and Mr Alejandro Henning (Argentina) as alternate members of the WHO Staff Pension Committee for three-year terms until May 2016.

**It was so decided.<sup>1</sup>**

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<sup>1</sup> Transmitted to the Health Assembly in the Committee's second report and adopted as decision WHA66(11).

## **7. ORGANIZATION OF WORK**

The CHAIRMAN announced that, according to the agreement by the General Committee on the allocation of work to the main committees,<sup>1</sup> and following consultation between the vice-chairmen of Committees A and B and the President of the Health Assembly, it had been proposed that agenda items 17 (Health systems) and 18 (Progress reports) be transferred from Committee A to Committee B. She asked whether the Committee was willing to accept the transfer.

**It was so agreed.**

**The meeting rose at 11:55.**

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<sup>1</sup> See the summary record of the second meeting of the General Committee, section 2.

### **THIRD MEETING**

**Thursday, 23 May 2013, at 14:30**

**Chairman:** Mrs K. TYSON (United Kingdom of Great Britain and Northern Ireland)

#### **1. MANAGEMENT AND LEGAL MATTERS: Item 24 of the Agenda (continued)**

**Follow-up of the report of the Working Group on the Election of the Director-General of the World Health Organization:** Item 24.1 of the Agenda (Documents A66/41 and EB132/2013/REC/1, resolution EB132.R14)

Ms CHEDEVILLE-MURRAY (France), speaking on behalf of the Member States of the European Region, expressed firm support for the draft resolution recommended by the Executive Board for adoption by the Health Assembly in resolution EB132.R14. The draft resolution was the outcome of a lengthy and complex process and would ensure a more robust procedure for the election of future directors-general. In that regard, she welcomed the institution of a code of conduct and of a candidates' forum through which candidates could present themselves to Member States on a fair and equitable basis. The introduction of a standard curriculum vitae form would ensure that compliance with the criteria as revised by the Executive Board, and the proposed amendments to the Rules of Procedure of the Executive Board and of the World Health Assembly, were satisfactory. The request for the Secretariat to explore options for the use of electronic voting for the appointment of the Director-General, including the financial implications thereof, and to report thereon to the Sixty-seventh World Health Assembly was also welcome, on the understanding that the Board and the Health Assembly would continue to come to decisions by secret ballot, in accordance with Rule 52 of the Rules of Procedure of the Executive Board and Rule 108 of those of the Health Assembly. Similarly welcome was the principle of consolidating in a single reference document the description of the overall process for the election of the Director-General.

Mr OSEI (Ghana), speaking on behalf of the Member States of the African Region, said that one of the greatest strengths of WHO was the rich diversity of its membership, which must be given full expression in the appointment of its staff and management, including at the highest level of the Organization. Bearing in mind the issues identified by the Working Group on the Election of the Director-General as being critical to reform of the election and appointment process, he welcomed the introduction of a candidates' forum in that it would give all Member States the opportunity to assess and interact meaningfully with candidates. The adoption of a code of conduct would also help to ensure a level playing field, thereby safeguarding the integrity of the electoral process. Noting the voluntary nature of the application of the code of conduct, the Member States in his Region would keenly follow the willingness of candidates to comply with the code as a marker of their integrity, which was an important factor from the perspective of those Member States. The revision of the Rules of Procedure of the Executive Board and the World Health Assembly to allow for the nomination of more than one candidate by the Board for consideration by the Health Assembly represented a fundamental enrichment of the election process, underscoring the collective will of Member States to infuse greater transparency, fairness and inclusiveness into that process. Due regard must nonetheless be paid to the principle of equitable geographical representation, not forgetting that candidates appointed to the post of Director-General had thus far hailed from three of the six WHO regions. The process should continue to be guided, however, by the paramount consideration of the highest standard



of efficiency, competency and integrity. He endorsed the draft resolution and looked forward to its effective implementation.

Mr KIM Young-hak (Republic of Korea), expressing full support for the draft resolution, said that the code of conduct would serve as a model for all international organizations. As a representative of the directing and coordinating authority for health within the United Nations, the Director-General of WHO should possess the requisite qualifications, demonstrate a balanced perspective on global health issues and have the courage and confidence to make bold decisions in emergency situations. In order to ensure that WHO continued to be led by an individual with strong commitment and qualifications, concerted efforts must be made at all levels to ensure implementation of the resolution. In particular, the page of the WHO web site dedicated to information disclosed by candidates, referred to in Annex 2 to the draft resolution, should be fully utilized in the interest of informed decision-making by Member States concerning the selection of a candidate qualified to oversee the Organization's programmes for improved global health.

Dr SHOHANI (Iraq) said that, in order to guarantee the principle of fairness, equality and equal opportunity, the post of Director-General should be rotated among the different WHO regions, provided that the candidates had the necessary competence and expertise, qualifications that were not lacking in any of the regions. Regions and Member States should also be invited to submit proposals for mechanisms designed to ensure that the election process was conducted in a professional, transparent and fair manner.

The CHAIRMAN said she took it that the Committee wished to approve the draft resolution.

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

**Real estate:** Item 24.2 of the Agenda (Documents A66/42 and A66/62)

Dr THABET NASHER (Yemen), speaking in his capacity as Chairman of the Programme, Budget and Administration Committee of the Executive Board, introduced the Committee's report on the item, which was contained in document A66/62. The Committee, on behalf of the Executive Board, had recommended that the Health Assembly adopt the draft resolution contained in that document, which concerned the construction of the new WHO sub-office in Garowe, Puntland, Somalia.

Dr DIAKHABY (Guinea), speaking on behalf of the Member States of the African Region and referring to the project options for achieving a site-wide, comprehensive refurbishment strategy for WHO headquarters, said that option 1 was preferable to the other three options for the reasons set out in the Secretariat's report (document A66/42). Of those reasons, she highlighted: the cost advantages offered by the possibility of disposing of the three annex buildings L1, L2 and M, which would be made redundant by the construction of a new low-maintenance, low-energy building; the access to Host State loans for new construction; the most flexible use of space; easier compliance with local legislation; and less disruption during the works. She called on the Health Assembly to take note of the Secretariat's report, to provide guidance concerning the updated refurbishment strategy and to approve the construction of the new WHO sub-office in Garowe, Puntland, Somalia.

Ms HERNÁNDEZ NARVÁEZ (Mexico) acknowledged the need to adopt a longer-term strategy for the management of WHO's real estate and therefore welcomed the proposals aimed at establishing an integrated strategy that took account of building conditions. The strategy should also

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<sup>1</sup> Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA66.18.

take account of the need to reduce operational costs in the long term; additional information on the possible savings would therefore be useful. She noted that the financing mechanism presented would have no additional financial implications for the Member States in the coming biennial budgets. In view of the renovation projects being carried out at the headquarters of other multilateral organizations and their serious financial implications for the Member States, she gratefully acknowledged the Director-General's commitment to absorb project costs within the financing mechanism presented. She supported the draft resolution.

Ms BULLINGER (Switzerland) said that the Secretariat's report provided a solid basis for further discussion and decision-making concerning the Organization's long-term real estate strategy. Project option 1 appeared to offer significant long-term cost and sustainability advantages, but it should be noted that the Host State's agreement to a loan for new construction would be subject to approval by the Swiss Parliament. Switzerland would continue to work in close collaboration with WHO for the best possible solution.

Mr BERTONI (Italy), referring to the whole-life cost of options set out in Table 6 of the Secretariat's report, asked whether the amount of US\$ 82.5 million anticipated from the sale of the three annex buildings under option 1 was based on expert evaluations.

Mr ESPINOSA SALAS (Ecuador) said that any plan to renovate WHO's real estate must take account of the need to provide adequate facilities for people with disabilities, in line with the draft resolution currently before the Health Assembly under item 13.5, Disability.

Mr PRESTON (Operational Support and Services), responding to comments, said that disability access had thus far been facilitated only in areas that were not to be replaced through renovation, but that such access was treated as a matter of paramount importance in all new renovation projects, new constructions and total refurbishments, especially in the main building. With respect to access to a loan from the Host State, it was hoped that an agreement on the way forward could be reached in principle during the session of the current Health Assembly in order to formalize the informal negotiations that had taken place on that score over the previous few months. He expressed appreciation to the Government of Switzerland for its collaboration with WHO in developing the refurbishment strategy. The amount indicated under option 1 for the sale of the three annex buildings was indeed based on expert advice provided by a local firm of architects. Additional studies were being undertaken, however, in order to qualify that initial evaluation.

He added that the refurbishment proposals considered in 2010 had covered only seven floors of the main building, whereas the strategy now before the Health Assembly covered the entire WHO compound on the basis of the expected 40-year life span of the buildings. It was therefore a comprehensive long-term strategy that had taken considerable time to prepare, albeit on a less formal basis than desired. Full and detailed plans would be submitted to the Organization's governing bodies in 2014. Every effort had been made to validate the content of the strategy, and he expressed confidence that WHO could implement it without unduly affecting the financing mechanism approved in 2010.

The CHAIRMAN said she took it that the Committee wished to note the Secretariat's report and to approve the draft resolution contained in document A66/62.

**The Committee noted the report.**

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

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<sup>1</sup> Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA66.19.

**Agreements with intergovernmental organizations:** Item 24.3 of the Agenda (Document A66/46)

The CHAIRMAN drew attention to the draft resolution on the proposed agreement between WHO and the South Centre contained in document A66/46.

Dr LIU Peilong (China) said that the South Centre had facilitated collaboration among developing countries and played a major role in promoting United Nations activities and South–South cooperation. Striving as it did to promote the Centre’s activities, China was in favour of the proposed agreement between WHO and the Centre; it would formalize the relationship between the two and further their long-term collaboration. He therefore supported the draft resolution.

Mrs GOONERATNE (Sri Lanka) remarked that developing countries, including her own, needed to collaborate and work doubly hard in order to achieve their objectives. They therefore welcomed constructive support, such as that crucially provided over the years by the South Centre, on multilateral policies in a variety of areas including health. The South Centre was well known and its personnel were experienced, skilled and extremely competent in health and development issues. She likewise supported the proposed agreement and the draft resolution.

Mr ROSALES LOZADA (Plurinational State of Bolivia) said that the South Centre was an intergovernmental organization whose support and cooperation as an adviser, source of publications and centre for debate on health and other multilateral matters was highly appreciated by his country. He therefore endorsed the establishment of a relationship between WHO and the South Centre and supported the draft resolution.

Dr RANJAN (India) welcomed the proposed agreement between WHO and the South Centre, which played an important role in WHO’s work on multilateral health and development policies. He too expressed support for the draft resolution.

Mr ESPINOSA SALAS (Ecuador) said that his country had benefited in the past from fruitful cooperation with the South Centre on various matters including health. He endorsed the views of previous speakers on the value of the constructive advice, which was sometimes critical, offered by the South Centre to WHO, and expressed support for the draft resolution.

Mr AMRI BUKHAIRI BAKHTIAR (Malaysia) said that Malaysia had from the outset benefited from the work done by the South Centre in providing analytical assessments in such areas as health, intellectual property, trade and development, and environment. Together with other inputs by the Centre, such assessments had supported developing countries in formulating strategic and concrete positions on key issues at international meetings and conferences. A formal relationship with WHO would benefit both organizations. The international multilateral system was complex, and the South Centre played an increasingly significant role as a think tank and an instrument for facilitating and further promoting South–South cooperation. It remained the only institute in a position to provide intellectual support to developing countries in multilateral negotiations and international dialogue. He therefore supported the draft resolution.

Ms BLACKWOOD (United States of America), appreciative of the strong support expressed for the South Centre and of the excellence of its work for South–South cooperation, commented on the need to ensure protection for WHO, as an evidence-based organization, from vested interests of any kind. She nevertheless supported the proposed agreement.

Mr RUSH (United Kingdom of Great Britain and Northern Ireland) expressed support for the proposed agreement; engagement by all non-Member State actors in the work of providing capacity-building and intellectual and policy support to developing countries was decidedly important. For

WHO, the primary interest lay in promoting global health and supporting the poor and vulnerable. All partners, Member States and non-Member States must therefore work together in a positive and constructive manner to achieve the Organization's global health objectives.

Dr SUWIT WIBULPOLPRASERT (Thailand) said that the South Centre championed intellectual capacity-building, in particular in order to help developing countries to deal with the impact of international trade and intellectual property regimes, as well as to protect the interests of poor people. The proposed agreement between WHO and the South Centre would further develop the latter's role in that context and he therefore strongly supported the draft resolution.

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

## **2. COLLABORATION WITHIN THE UNITED NATIONS SYSTEM AND WITH OTHER INTERGOVERNMENTAL ORGANIZATIONS: Item 25 of the Agenda (Document A66/44)**

The CHAIRMAN pointed out that in paragraph 16 of the Secretariat's report (document A66/44), the figure at the end of the first sentence should read US\$ 134 million and not US\$ 34 million.

Ms CALDER (Switzerland), speaking on behalf of Australia, Denmark, Finland, France, Netherlands, Norway, Switzerland and the United Kingdom of Great Britain and Northern Ireland, and supported by Dr CARTIER (Belgium), said that a strong commitment to a more efficient, effective and coherent United Nations system was essential for achieving maximum development results. Effective coordination among organizations of the United Nations system and other relevant actors was a key element of those efforts, which were of growing importance in a global landscape of multiple new stakeholders. The recently adopted United Nations General Assembly resolution 67/226 on the quadrennial comprehensive policy review of operational activities for development of the United Nations system demonstrated the strong international consensus on the issue; the Resident Coordinator System and the "delivering as one" approach provided for in that resolution were central to the efforts to enhance coherence. The organizations of the United Nations system had moreover reached welcome agreement on sharing the costs of coordination that served the entire United Nations system, including WHO's programmatic activity.

WHO's commitment to improving the United Nations system in support of better development results and its factoring of the necessary coordination costs into the proposed programme budget 2014–2015 were also welcome. In that light, however, the implication in parts of the report that the Secretariat harboured doubts as to the usefulness of the United Nations development system and of United Nations coordination was therefore somewhat surprising. It would be interesting to hear the Secretariat's views on the matter and gratifying to receive reassurance of its continuing full commitment to an efficient and effective United Nations coordination system. Member States must hold themselves accountable for demonstrating coherence in United Nations forums and should accordingly feel under an obligation to discuss and underline the importance of coherence.

Mr HOLM (Sweden), endorsing the statement made by the delegate of Switzerland, expressed support for the Development Operations Coordination Office and for its work to secure the resources and staff required for coordination efforts at country level. While there could be some merit both in WHO's focus on the implications of the quadrennial comprehensive policy review resolution as it pertained to the funding of United Nations coordination and in its questioning of the concept of coordination as currently implemented, he underlined the fact that the United Nations Development

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<sup>1</sup> Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA66.20.

Group had decided only a few weeks earlier on a cost-sharing agreement. He noted with appreciation that the amount included for coordination in the WHO proposed programme budget 2014–2015 was as stated in that agreement. Until such time as the current practices for coordinating United Nations activities at country level had been revised, all participating organizations must pay their fair share of costs. WHO should continue its commitment in that regard.

Dr SHOHANI (Iraq) said that cooperation within the United Nations system and with other international organizations led to optimum use of resources and prevented the duplication of programmes and activities. In Iraq, the United Nations Development Assistance Framework had promoted an effective partnership between ministries and relevant stakeholders, paving the way for partnership with other supporting bodies and organizations. In that context, a technical advisory group, formed as part of a primary health care project supported by the United States Agency for International Development, convened regular meetings, attended by staff from organizations of the United Nations system, to ensure integrated planning and follow-up and to promote the concept of primary health care throughout the country. The Government of Iraq had also strengthened that approach by sharing in the costs, with a view to obtaining the support needed for joint financial planning to improve primary health care activities and thereby attain Millennium Development Goal 8 (Develop a global partnership for development).

Dr TROEDSSON (Executive Director, Office of the Director-General) expressed appreciation for all the comments made on the subject during the consultations held at the global, regional and country levels and at the present meeting. He wished to make it abundantly clear that WHO was fully committed to United Nations coordination and collaboration at all levels. Any misinterpretations to which the report may have given rise were inadvertent; there had never been any question of not working together, “delivering as one”, cooperating or collaborating. The intention of the report had been to reflect not the WHO position, which had been explained by the Director-General on numerous occasions, but rather some of the negotiations that had taken place within the United Nations Development Group and among organizations of the United Nations system. As described in the report, those negotiations had focused on how fairly to divide among the United Nations Development Group organizations the additional costs for the Resident Coordinator System following the withdrawal of donor support. WHO’s share, which it would honour, had been estimated at US\$ 5.2 million per biennium. It should be noted, however, that not all WHO activities at country level were included in the United Nations Development Assistance Framework or in the One United Nations programme, in so far as legitimate requests for support might be received from Member States concerning highly specific public health issues that fell outside the United Nations mandate. In conclusion, he reiterated the WHO commitment to working actively in coordination with other organizations at the country level and to taking on all the responsibilities of a technical agency.

**The Committee noted the report.**

### **3. HEALTH SYSTEMS:** Item 17 of the Agenda

#### **Universal health coverage:** Item 17.3 of the Agenda (Document A66/24)

Professor PISAKE LUMBIGANON (Thailand), speaking on behalf of the Member States of the South-East Asia Region, recalled that the United Nations General Assembly had committed to universal health coverage in December 2012 with the adoption of resolution 67/81 on Global Health and Foreign Policy. At the subsequent High-level Dialogue on Health in the Post-2015 Development Agenda, held in Botswana, and the meeting of the High-level Panel on the Post-2015 Development Agenda held in Bali, Indonesia, universal health coverage had been identified as one of the

overarching health goals for the post-2015 development agenda. Adequate numbers of competent health workers were the key to achieving successful outcomes in that regard, and preparing such workforces required effective and appropriate health workforce education systems. Such systems had been gradually transformed in the past 100 years and were no longer predicated on experience but rather on science and technology. Health care systems had been improved as a result, and life expectancy extended, but science-based health workforce education systems had gradually led to fragmentation, were technology-driven and entailed high costs. In December 2010, a Lancet Commission report, *Health professionals for a new century: transforming education to strengthen health systems in an interdependent world*, had served to kick-start a global process to reform health workforce education. A number of initiatives had since been tested and had proved the potential for positive results. The health workforce, its education and its training were among the most neglected of areas. In that context, 21 Member States from all six WHO regions (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) had submitted a 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 adequate number 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;<sup>1</sup>

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;<sup>2</sup>

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;

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;

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 health workforces; and that there is a need to improve the health workforce education and training system in response to country's health needs;

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<sup>1</sup> The world health report 2006: working together for health. Geneva: World Health Organization; 2006.

<sup>2</sup> Increasing access to health workers in remote and rural areas through improved retention, <http://www.who.int/hrh/retention/home/en/index.html>.

PP9 Mindful of the need for a comprehensive national policy and plan 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 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:<sup>1</sup>

- (1) To further strengthen national health policies, strategies and plans through intersectoral policy dialogue among ministries of education, health and finance to ensure that the health workforce education and training contribute to achieving universal health coverage;
- (2) To conduct comprehensive assessments of the current situation of health workforce education with the application of standard protocol and tool to be developed by WHO;
- (3) To formulate and implement evidence-based national policies and strategies, based on findings from the assessment in the previous paragraph, to strengthen and transform the health workforce education and training, including through the promotion of inter-professionals, 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 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 strategies for the strengthening and transformation of health workforce education;

2. REQUEST the Director-General and the Regional Directors:

- (1) To develop a standard protocol and tool for assessment, and to support Member States in conducting comprehensive assessments of the current situation of health workforce education with the application of the protocol which may be adapted to the country contexts;
- (2) To convene regional technical consultations to review the findings of country assessments and to formulate regional and global strategies on transforming health workforce education in support of the universal health coverage;

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

- (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;
- (4) To submit a progress report on the implementation of this resolution to the Sixty-ninth World Health Assembly through the Executive Board.

The financial and administrative implications for the Secretariat of the resolution's adoption were as follows:

<b>1. Resolution</b> Transforming health workforce education in support of universal health coverage	
<b>2. Linkage to programme budget 2012–2013 (see document A64/7 <a href="http://apps.who.int/gb/ebwha/pdf_files/WHA64/A64_7-en.pdf">http://apps.who.int/gb/ebwha/pdf_files/WHA64/A64_7-en.pdf</a>)</b>	
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)
<b>How would this resolution contribute to the achievement of the Organization-wide expected result(s)?</b>	
The resolution should lead to an increase in the number of countries that have an investment plan for scaling up and/or improving training and education of health workers in accordance with national health needs. This will involve an assessment of current practices, guidance and collaboration in order to transform education systems in support of a better response to people’s health needs.	
<b>Does the Programme budget already include the products or services requested in this resolution? (Yes/no)</b>	
Yes.	
<b>3. Estimated cost and staffing implications in relation to the Programme budget</b>	
<b>(a) Total cost</b>	
<b>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).</b>	
(i) Three years (covering the period 2013–2015)	
(ii) Total: US\$ 5.5 million (staff: US\$ 3.5 million; activities: US\$ 2.0 million)	
<b>(b) Cost for the biennium 2012–2013</b>	
<b>Indicate how much of the cost indicated in 3 (a) is for the biennium 2012–2013 (estimated to the nearest US\$ 10 000).</b>	
Total: US\$ 1 million (staff: US\$ 600 000; activities: US\$ 400 000)	
<b>Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant.</b>	
Headquarters and the six regional offices.	
<b>Is the estimated cost fully included within the approved Programme budget 2012–2013? (Yes/no)</b>	
Yes.	
<b>If “no”, indicate how much is not included.</b>	
<b>(c) Staffing implications</b>	
<b>Could the resolution be implemented by existing staff? (Yes/no).</b>	
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 guidance 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 develop tools and guidance, and to coordinate and monitor regional activities. In addition, six full-time equivalent staff members would be required, one in each regional office, with skills in health professional education and health systems.

#### **4. Funding**

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

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

US\$ 1.0 million; source(s) of funds: external, international donors.

He proposed that a drafting committee be established to consider the draft resolution.

Dr DAULAIRE (United States of America) said that the expansion of health care coverage, which was fundamentally about all people having equal access to care, was presently at the forefront of his country’s domestic agenda. The Affordable Care Act sought dramatically to expand access to health care services. It contained numerous provisions to keep costs low and promote prevention, and would ultimately extend coverage to 30 million Americans who were currently uninsured. Realizing universal health coverage was primarily the responsibility of national governments; WHO could serve as a powerful advocate and provide needed technical support, but national governments must assume ownership of that goal. Universal health coverage was a strong unifying element in the discussion of the post-2015 development agenda, but it was not an outcome in itself and must be accompanied by clear health targets and supported by evidence-based interventions. Such targets should focus on continuing achievement of the current health-related Millennium Development Goals. He expressed support for the addition of noncommunicable diseases to the discussion, with prevention as the cornerstone of sustainable universal health coverage.

Mr ÁLVAREZ LUCAS (Mexico), referring to United Nations General Assembly resolution 67/81 on Global health and foreign policy and the discussion about including universal health coverage on the post-2015 development agenda, commended the Secretariat’s efforts to formulate indicators that would help measure the progress made by each country towards ensuring access to health services independently of its specific characteristics and problems. Efforts would need to be intensified to meet the challenge of guaranteeing effective, high-quality access to health services for all.

Dr MAKUBALO (South Africa), speaking on behalf of the Member States of the African Region, welcomed the completion of the plan of action, which would help many countries in the African Region move towards universal health coverage despite the challenges many of them faced. *The world health report 2010* and the report of the WHO/World Bank ministerial-level meeting held in February 2013 clearly indicated that a successful transition required the spread of financial risks through prepayment and pooling, a reduction in out-of-pocket payments, additional funds for health where necessary, and an emphasis on primary health care and broader health system development. She was nevertheless concerned to note that the plan of action focused on health financing at the expense of elements such as increasing the quality and availability of health services. Greater emphasis should

be placed on improving the availability, accessibility, acceptability and quality of primary health care services. Full implementation of the various declarations on primary health care and health systems would ensure that services reached poor and marginalized communities, especially in low- and middle-income countries, and had the greatest potential to make affordable improvements in population coverage. It was also important to strengthen facility and district health management systems, enabling them to be more responsive to the needs of communities and to the incentives created through active purchasing. Steps in that direction should be accompanied by mechanisms and processes that supported accountability, community participation and ownership.

People's survival and health were among the most fundamental of development outcomes. The goals, policies, programmes and resource flows from national and international players should therefore address unfair and avoidable inequalities in those outcomes.

Ms JACOB (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, the Republic of Moldova, Armenia and Georgia aligned themselves with her statement. Universal health coverage was an important means of achieving healthier lives for people and was also a goal in itself. It contributed to the realization of health equity and enjoyment of the right to health. A minimum set of services was not sufficient. Effective universal health coverage required a health system with sufficient human, technical and financial capacities to provide good-quality services that were accessible to and answered the needs of all. It should comprise targeted efforts for poor, vulnerable and marginalized segments of the population that were particularly at risk of financial hardship from excessive out-of-pocket payments. To address the broader determinants of health, and given that all aspects of health should be covered, from promotion to rehabilitation, effective universal health coverage required a health system with broad public health measures. It also required a multisectoral "health in all policies" approach conducted in collaboration with, and with support from, ministries such as finance, trade, labour and social affairs, as well as civil society and the private sector. In order to address the demands from countries about how to elaborate a system of universal health coverage, development partners should align their efforts and coordinate their inputs for capacity development, preferably through existing partnerships such as Providing for Health and the International Health Partnership. The European Union firmly believed that universal health coverage had a key role to play in the post-2015 development agenda since it could make a significant contribution to sustainable development and help contain new and existing health threats.

Mr S. DIOUF (Senegal) said that his country, which was a member of the United Nations Foreign Policy and Global Health Initiative and in which access to health care remained a problem for many people, commended the importance attached to universal health coverage. However, document A66/24 should have allowed for better definition of strategic approaches to achieving universal health coverage and should have attached crucial importance to strategies for providing medical treatment to the poorest and most vulnerable sectors of the population. For example, the health maps for each country, mentioned in paragraph 15, should be updated to take account of the goal of universal health coverage and thereby prompt an effort to narrow the gap between health care supply and demand. There was also a need to understand the limits to the development of mechanisms offering protection against financial risks, so that appropriate reforms could be introduced in order to move towards universal health insurance; and to take action against preventable diseases through a stronger commitment to a multisectoral approach to dealing with the social determinants of health, so as to ease the morbidity burden and thus make more efficient use of health-sector resources.

Ms BOTERO HERNANDEZ (Colombia) said that, as stated in the report, universal health coverage was contingent on the availability of health services at an affordable price, a critical aspect of which was equitable access to medicines. In recent years, however, different parts of the world had suffered shortages of essential medicines, and they had been displaced by therapeutic alternatives which, while relevant and effective, were more costly and therefore had an impact on the financial

sustainability of health systems. Her country had recently embarked on a process of consultation with other countries and regions to analyse the problem and tackle it from three angles: gaining a clearer understanding of what caused the shortages, in order to prevent and mitigate the resulting problems; conducting a worldwide evaluation of the extent and nature of the shortages; and developing strategies to manage shortages and strengthen the concept of essential medicines as part of the process leading to universal health coverage. The aim was to make tackling the shortages a WHO priority, so as to obtain the Organization's support. Colombia supported the inclusion of universal health coverage on the post-2015 development agenda.

Mr AL-SHEHABI (Bahrain) said that, in common with other countries, Bahrain faced challenges that threatened the sustained delivery of good-quality health services in the current economic climate, not least the high costs of health care, compounded by such factors as an ageing population, an increase in chronic diseases and wasted spending. The demand for high-quality health care also stepped up pressure on politicians to develop financing options for moving towards universal health coverage. Bahrain was currently working to build national capacities for providing such coverage, and consultations were under way with the legislature on the best way forward to achieving that aim, which was perhaps a goal to be included on the post-2015 development agenda. It was essential to evaluate and monitor progress towards universal health coverage in order to appraise successes and work on ways of overcoming any obstacles that might arise.

Dr HORI (Japan) said that Japan's national health insurance scheme, introduced 50 years earlier, ensured that all citizens had access to essential health care services whenever necessary. The scheme constituted a solid base from which to boost public health and had provided a strong backbone for subsequent socioeconomic development. Although universal health coverage was an important common goal for the global health community, the many factors to be considered complicated its promotion and achievement. Working towards universal health coverage required ongoing national efforts to improve the availability and quality of health care services, and to establish and manage mechanisms for protecting the population from financial risk. Japan and the World Bank had started a joint research project on universal health coverage in 2012. On the basis of the findings, Japan planned to organize an international training course later in the year for high-level officials from developing countries. In its recently announced strategy for global health diplomacy, Japan explained how it intended to use its knowledge to expand international cooperation for global health. The strategy's ultimate goal was universal health coverage. Japan would continue to share its experiences and contribute to health system strengthening through bilateral and regional cooperation.

Ms CALDER (Switzerland), expressing satisfaction at the considerable progress made towards universal health coverage worldwide, said that such coverage provided a framework for meeting the challenges facing the global effort to strengthen equitable, efficient and sustainable health systems. Major inequalities remained in terms of health coverage and financial risk, not only between but also within countries, and urgent action was needed to ensure more equitable access to health services and information and to take into account the social determinants of health. A multisectoral approach, bringing together health players and those from other sectors, was crucially important to allow for consideration of the social, economic and environmental determinants that had a direct impact on the reduction of inequality and enabled sustainable development. The concept of universal health coverage was a pertinent and useful means of measuring progress towards sustainable development. A social health protection system providing universal health coverage was therefore a key instrument for attaining the global health objective. In the light of discussion of the post-2015 development agenda, WHO should strengthen its role of coordinating and supporting country efforts to implement universal health coverage; efforts should include continuing development of the Providing for Health initiative.

Mr SANNE (Norway) said that Norway had sponsored the draft resolution in recognition of the importance of health personnel to the achievement of universal health coverage. He expressed support for the establishment of the drafting group chaired by Thailand.

Mr ARKO HANANTO BUDIADI (Indonesia) said that Indonesia, a sponsor of the draft resolution, considered that, through universal health coverage, countries would strengthen their people's health and in turn obtain a development dividend. Indonesia was working to expand health coverage and services to all Indonesians by 2019. In cooperation with the Non-aligned Movement Centre for South-South Technical Cooperation, it had been conducting global health diplomacy for health professionals and related personnel in the South-East Asia Region for some years.

Dr LUCO (Chile), recalling that her country had been working for 50 years towards universal health coverage, said that Chilean legislation incorporated a system of universal access with explicit guarantees for a group of diseases, known as Plan Auge. Under the plan, her country was implementing strategies that took account of the need for universal health coverage, in particular for vulnerable groups and for diseases meeting priority criteria, and included preventive activities. The plan currently covered about 60% of the disease burden and ensured access, timely treatment, financial protection and a recently incorporated quality guarantee for the population. Per capita health expenditure varied widely depending on whether the people concerned were covered by the private or public components of the Chilean health system. In addition, many people insured under the public health system were treated by private service providers covered by the public insurance. The out-of-pocket component, which in Chile was estimated at 40% but again varied widely, was an even more complex aspect of spending. In view of those conditions, her country supported the call for progress towards universal health coverage, integral care, solidarity and income redistribution.

Dr ROZITA HALINA TUN HUSSEIN (Malaysia) expressed strong support for multisectoral involvement to achieve universal health coverage. Malaysia, which was a sponsor of the draft resolution, suggested that WHO should strengthen the modalities for enhancing understanding among non-health government sectors and others of the importance of strong support and funding for health. WHO should develop an effective manual and training package for stakeholder engagement and strategic communication. In order to engage with non-health agencies, particularly financial and economic authorities, it would be useful to have summary indicators and "dashboard-type" user-interface modalities providing information on universal health coverage, health financing and equity status. Countries would need technical support to learn how to use such tools, draw the right conclusions and establish policy directions.

She commended efforts to foster sharing of experiences between countries and practitioners and suggested that WHO might wish to strengthen cooperation with networks such as the Joint Learning Network for Universal Health Coverage, which involved nine practitioner countries from the African, South-East Asia and Western Pacific regions. Budget constraints had made WHO less inclined to foster such forums, yet it was international agencies that had the capacity and opportunity to bring numerous countries together on common agendas. She also expressed support for WHO's efforts to develop other building blocks beyond health care financing, as they were important for achieving quality health care services and universal health care. WHO could go further by making tools readily available in the public domain, for example in the form of computer software for patient management systems and for monitoring and evaluation of efforts to achieve universal health coverage, and by helping Member States to establish legal and regulatory frameworks to enable good governance, enforcement, monitoring and evaluation of services in the private and the public sectors, patient safety and quality of care.

Mr KIM Young-hak (Republic of Korea) commended WHO for giving priority to universal health coverage and welcomed its collaboration with the World Bank to that end. The key to universal health coverage, as previous speakers had said, was financing strategies; Member States needed

support to develop appropriate financing mechanisms to ensure that people were not impoverished by the excessive cost of health care.

The Republic of Korea had introduced a financing mechanism for universal health coverage 25 years earlier but was still working to expand coverage. Universal health coverage was an ongoing undertaking; expansion must always be weighed against financial sustainability, and striking a balance between the two was a strenuous job that required public understanding and social consensus. Universal health coverage was an important means of achieving better health outcomes and should be one of the post-2015 health goals.

The Republic of Korea was willing to share its expertise and experience to help Member States develop their universal health coverage financing facilities, bilaterally and multilaterally. In that connection, it would make a voluntary financial contribution of US\$ 1 million annually for the next five years to WHO activities to that end.

The CHAIRMAN thanked the Republic of Korea for that contribution.

Mr LI Mingzhu (China) thanked the Secretariat for the help it had given Member States to realize universal health coverage. Thanks to the joint efforts of the Secretariat and Member States, great progress had been made towards universal health coverage worldwide in that regard. In China, basic health coverage had increased in the previous decade from less than 30% to more than 95%; it had also broadened in scope and covered more items.

WHO should clarify what was meant by universal health coverage, that is, what were the key components, what percentage of the population was covered, what percentage individuals would be required to pay, what the service package comprised, and what was an acceptable reimbursement ratio. The Secretariat should continue to support Member States in developing strategies for the introduction of universal health coverage that were based on national specifics, set a timetable and defined a road map for step-by-step progress. Legislation and regulations provided crucial institutional safeguards for the implementation of universal health coverage. Document A66/24 should therefore have recommended the adoption of legislation on universal health coverage so as to facilitate policy implementation. Finally, the Director-General should take steps to convey the importance of universal health coverage to nongovernmental organizations so as to encourage them to shift their investment focus to developing countries that required help in achieving that goal.

Mr JONES (Canada) said that universal access to health care was a fundamental principle of the Canadian health care system. He supported the efforts of the international community to extend universal coverage but recognized that countries could use different approaches to implement it. He commended the countries that had taken concrete steps to achieve universal health coverage and reduce inequalities. In the context of the post-2015 development agenda, Canada encouraged the emphasis that universal health coverage placed on strengthening the capacities of health systems as opposed to vertical approaches.

Mr HO (Singapore) endorsed Malaysia's view that the Secretariat had a unique role to play in bringing together Member States on the universal health coverage agenda. As underscored in the Secretariat's report, the achievement of universal health coverage had gained traction with the international community, and the push to include it on the post-2015 development agenda was a further demonstration of its close links with sustainable development and the ultimate goal of poverty eradication. The process of achieving universal health coverage was nonetheless complex, and every Member State should adopt the solution best suited to its unique circumstances. As mentioned by previous speakers, universal health coverage must be affordable and sustainable, it must ensure that nobody was denied good-quality health care because of the inability to pay, and it must encourage patients and doctors to choose effective health care that was appropriate to their needs. Each country must also design its own system for financing, whether through taxation, social insurance or a medical

savings fund, adopting the features that worked and refining them in the light of the changing environment.

Dr AL WAHAIBI (Oman), applauding in particular the plan of action to support Member States in developing financing strategies for moving towards universal health coverage, said that despite the critical shortage of health workers and the difficulty of retaining such workers in underserved areas, Oman was working hard to develop national human resources in various fields, in line with development plans. He echoed the comments made by the delegate of Bahrain concerning the challenges to health service delivery and affirmed the importance of sound management and an appropriate level of health spending.

Dr SHOHANI (Iraq) said that universal health coverage in Iraq was monitored through the national health account and other activities related to health economics, as had been recommended by a conference on development of the country's health system. Emphasis was placed on the need to balance economic feasibility and cost with the impact on primary health care services and their integration with secondary and tertiary services. The aim was to achieve universal coverage while keeping costs down through the application of quality-related components.

Ms ALI (Maldives) thanked the Secretariat for its leadership and support in helping Member States to move towards universal health coverage. The regional strategy for universal health care, approved by the Regional Committee for South-East Asia at its sixty-fifth session, would steer efforts to achieve evidence-based, equitable and efficient health systems focused on primary health care. During the Regional Committee session, Member States had emphasized the importance of public funding in ensuring social protection; expenditure on pharmaceuticals was one of the largest contributors to out-of-pocket payments in the Region, especially in small countries like hers, which were totally dependent on imported drugs, made extensive use of costly brand-name medicines, required low volumes and faced additional costs because of their geography. In Maldives, medicines accounted for 17% of total health expenditure, prompting the country to explore ways of reducing costs, for example by expanding the use of generic medicines and making bulk purchases. She expressed appreciation for WHO's support in that regard and urged the Secretariat to continue helping small Member States work on supply-chain management and bulk purchases of medicines of assured quality. Maldives had launched a universal health insurance scheme in 2012 to ensure the availability of a basic health care package for all citizens. It had also introduced telemedicine services in 39 islands across the country. However, the fragmented and dispersed nature of the country's islands and the high dependency on expatriate health care workers made providing access to quality health services extremely difficult. She supported the inclusion of universal health coverage in the post-2015 development agenda.

Mr KLEIMAN (Brazil) said that a universal, public, integral and equitable health system was a prerequisite for attainment of the Millennium Development Goals by 2015. In Brazil, where health was a right enshrined in the Constitution and a State obligation, the system had been improved in order to guarantee universal coverage. Simple measures had been taken in recent years to reduce costs and enhance efficiency, including strengthening management and assistance capacity, regulating private health plans and establishing a health industrial complex. Civil society participation in federal, provincial and municipal health councils had lent transparency to and broadened participation in the public policy process. In May 2013, the health ministers of Brazil, the Russian Federation, India, China and South Africa (the BRICS countries) had agreed to identify national institutions that would work with WHO to develop a monitoring framework to help countries track their progress towards achieving universal health coverage, which was a key means of promoting equity and a rights-based approach to sustainable development.

Mr ABDALLAH QASEM (Jordan), expressing support for the goal of universal health coverage, said that his country had made progress in that direction. The provision of appropriate, affordable and accessible health coverage for all was an economic challenge and an ongoing process. The question of sustainability required further consideration if success was to be guaranteed.

Dr DE ROSAS VALERA (Philippines) thanked the Secretariat for the support it provided to the Philippines and to other countries with regard to universal health coverage, which constituted her Government's strategy to improve access to affordable and quality health care and provide financial risk protection to all Filipinos, especially those who were poor. Key aspects of universal health coverage in the Philippines were the expansion of national health insurance coverage through a national Government-sponsored programme; the scaling up of preventive programmes and health promotion; and investment in infrastructure and the health workforce to improve clinical and management processes and regulate the quality of care. Providing coverage for neglected populations, including indigenous peoples, street families, orphans and people with disabilities, was a major challenge. Progress towards universal health coverage meant extending coverage not only of health services but also of the types of intervention that qualified for benefits. The payment mechanism required serious study, and interventions must be well developed and supported by a robust information system providing timely evidence for sounder decisions. The Secretariat was requested to support the promotion and use of health technology assessments and the strengthening of capacity to monitor financial risk and manage hospitals.

Dr TONG THI SONG HUONG (Viet Nam) said that in order to achieve universal health care in her country, the budget allocation for health would have to be increased to at least 10% of the total national budget, with priority being given to poor and near-poor populations, children under six years of age, ethnic minorities and social welfare recipients. Efforts would also have to be made to improve the network of health facilities, especially at the district and community level, to expand the benefit package and to improve financial protection for the insured. Universal health coverage was not about achieving a fixed minimum package, it was a process that needed to make progress on several fronts: the range of services available, the proportion of costs covered, and the proportion of the population covered. It should be included as a health-related development goal on the post-2015 development agenda.

Dr JAIN (India) said that India's health care system consisted of a mix of public and private health care providers, with service availability and quality varying considerably in both sectors. The availability of tertiary care in particular was a serious problem for many people, and out-of-pocket expenditure on health was very high. India's current five-year plan (2012–2017) set out a strategy for the gradual introduction of universal health coverage whereby total public funding for core health services would increase threefold compared with the previous five-year plan. Primary health care services would be strengthened, and the primary, secondary and tertiary sectors would be integrated. India remained committed to advancing its universal health care agenda.

Ms HARB (Lebanon) agreed that equitable access to good-quality, affordable health care services should be a cornerstone of the post-2015 development agenda, and stressed the importance of well-defined indicators for monitoring the progress of Member States towards universal health coverage. Lebanon had managed to lower out-of-pocket spending by adopting targeted policies and strengthening primary health care services. It could do still more in that direction, notwithstanding the limited public funding available. It called on WHO for support in finding the best ways of coordinating health service financing, given the presence of various financing mechanisms, multiple public funds and a strong private sector. Strengthening the health care system at all levels, on the basis of social protection and of health as a human right, required political commitment at the highest level.

Dr RODRÍGUEZ (El Salvador) remarked on the timeliness of the discussion, given that universal health coverage was a challenge in most countries during the current period of economic crisis and changing disease burdens. In El Salvador, health care reform was aimed at universal coverage, and great efforts were being made to increase the number of births attended by qualified personnel, to lower maternal mortality rates, to raise immunization coverage, to provide free health services and to lower out-of-pocket expenses. The reform process had tackled three problems: economic barriers, by providing free health care; geographical barriers, by bringing health services closer to the neediest to improve access; and the quality barrier, by improving the quality of care. International solidarity had been a key aspect of efforts to achieve universal health coverage. PAHO, for example, was currently supporting the establishment of a centre of excellence for integrated health service delivery networks in the Ministry of Health of El Salvador, in order to offer internships to people from countries in the Region that were working towards universal coverage, the aim being to compare and study the functioning of universal health care models.

Ms CHERQAOU (Morocco) expressed the hope that the Secretariat's report would serve as a basis for garnering more support for universal health coverage during the forthcoming discussions on the post-2015 development agenda, and would help to influence political decision-makers in Member States concerning the need to achieve that objective. The two challenges to be overcome were those of facilitating access to health services for all, without discrimination, particularly for people with limited incomes, and removing the obstacles to an equitable financing mechanism for all social groups. The health needs resulting from the demographic and epidemiological changes in some countries had prevented timely achievement of the goal of universal health coverage. WHO and other development partners should provide those countries with technical and financial support as part of a joint action plan for moving towards the goal. The current situation must therefore be examined further and health financing policies and strategies must be developed.

Mr ELIAS (Ethiopia) said that Ethiopia had made good progress with regard to primary health care coverage in the past decade through strong political commitment and efforts centred on community mobilization. Universal health coverage should be one of the main items on the post-2015 development agenda, and should be given high priority by the WHO Secretariat, development partners and Member States. Sustained support for the health system was needed to ensure that the population continued to have equitable access to primary health care. It was also important to have a long-term vision of how to transform the existing primary health care coverage in the light of the anticipated epidemiological and demographic changes. International organizations and Member States should work in harmony to establish sustainable health care financing systems in developing countries that ensured access, particularly for poor and marginalized communities, and equity in the face of economic fluctuations.

Mr PALOPOLI (Argentina) said that securing the right to health required bringing about improvements in the conditions in which people lived, grew and died, and hence in health determinants, as well ensuring an effective health system. Universal health coverage was an essential means of responding to and preventing disease. It should not refer only to health care services, however. It must be part of a broader framework comprising a renewed primary health care strategy and action on the social determinants of health. Making progress towards universal health coverage, understood as access by all people without discrimination to a minimum package of basic preventive, curative and rehabilitative medical services, and palliative care, implied improving the overall health of the population and protecting people from the financial risk associated with the payment of medical goods and services.

National health systems financed by general tax revenues and provision of services without payment at the point of care, when properly implemented, had been effective in reducing out-of-pocket costs and had proven to be sustainable and responsive in the face of adverse economic circumstances and the growing emergence of high-cost services. In Argentina, everyone (whether



nationals or foreigners) had health coverage, either through compulsory or voluntary medical insurance systems or by receiving care from completely free public establishments funded out of the public purse. Nonetheless, greater efforts were needed to ensure that all people had access to quality health services in accordance with their requirements. Document A66/24 stated that many families were impoverished by out-of-pocket medical expenses. Argentina's experience showed that public programmes financed with tax revenues facilitated access to health care by the most vulnerable, promoted health and indirectly redistributed income even more effectively than social security programmes. Countries would have to overcome many difficulties before they had fair and equitable health systems. That would require intense efforts that involved the commitment of all Member States and the support of the Organization and its regional offices.

The CHAIRMAN took it that the Committee supported the proposal to establish an informal drafting group in order to consider the draft resolution.

**It was so agreed.**

(For continuation of the discussion, see the summary record of the fourth meeting, section 2.)

**The meeting rose at 17:15.**

## **FOURTH MEETING**

**Friday, 24 May 2013, at 09:35**

**Chairman:** Mrs K. TYSON (United Kingdom of Great Britain and Northern Ireland)

### **1. SECOND REPORT OF COMMITTEE B (Document A66/68)**

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

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

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

**Universal health coverage:** Item 17.3 of the Agenda (Document A66/24) (continued from the third meeting, section 3)

Dr USUBUTUN (Turkey) said that it was only through strong and efficient health systems that the burden of noncommunicable and communicable diseases could be reduced, and that the strongest health systems were those that provided universal health coverage. The two interrelated components of universal health coverage were equitable access to quality health services, ranging from prevention to palliative care; and general health insurance covering basic care, or direct public finance providing for free health service delivery. Supplementary health services should also be affordable and accessible.

Under its health transformation programme, Turkey had made remarkable progress since 2003 on various aspects of universal health coverage, with healthcare coverage reaching 98% of the population by 2011. Political commitment had been a key factor in the success of the programme, which showed that major improvements in health system performance could be achieved in a relatively short period of time under the right conditions. The lessons that could be drawn from Turkey's experience included: the need for careful sequencing of sound technical reforms to achieve quick and visible results, and thereby ensure continued political support; the importance of setting up a dedicated team; the building of communication channels at all levels; the management of resistance through evidence-based data; and the development of appropriate incentives for those involved in the reform. A global commitment to universal health coverage would help countries to stay on track to achieve the goal of health for all.

Ms TINOCO (Costa Rica) said that her country had been implementing legislation on universal health coverage for 35 years, and had achieved 92% coverage. In that connection, it was desirable to pay particular attention to indigenous and migrant populations and those living below the poverty line to develop social programmes in conjunction with health programmes, and to establish a single national database. It was also important to guarantee universal health coverage by means of intersectoral policies and to integrate national health policy into national development plans.

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<sup>1</sup> See page 311.

Dr CHEN (Chinese Taipei), noting that universal health coverage had become a powerful and unifying focus of the current Health Assembly, said that Chinese Taipei had been implementing a universal health insurance programme since 1995, as a demonstration of its commitment to the Alma-Ata principle of health for all. The programme was effective in health promotion, disease eradication and quality assurance and allowed people to choose the physicians and facilities they wished to use. Everyone in Chinese Taipei, including foreigners, was issued with a card that entitled them to comprehensive care in more than 19 000 facilities. Coverage was effective, affordable and sustainable because it was based on a single-payer system. Chinese Taipei would continue to offer training opportunities for Member States that wished to learn from its experience in that area.

Dr LUCHESI (World Vision International), speaking at the invitation of the CHAIRMAN, said that universal health coverage could be a matter of life or death; many could not afford out-of-pocket payments for essential services, and many of those who could pay experienced severe financial hardship as a result. Greater efforts were needed to remove user fees at the point of use as they were one of the biggest barriers to progress in improving access to health care for poor populations, leading to higher rates of infant, child and maternal mortality and morbidity. Removing user fees could also have an immediate effect on the uptake of services, but governments must ensure that official fees were not merely replaced by informal payments. Health funding should come from prepaid and pooled contributions; social health insurance mechanisms performed badly in terms of covering those outside of formal employment, whereas tax-financed mechanisms had been proven to work regardless of a country's level of economic development. Universal health coverage must be defined as equitable access to appropriate, promotive, preventive, curative and rehabilitative health care for all people when they needed it, at an affordable cost. It should explicitly include the social determinants of health, including access to adequate sanitation, water and nutrition. Where necessary, coverage should be phased in, with an initial emphasis on free maternal, newborn and child health interventions, and the empowerment of families and communities to take control of their own health.

Mrs CALDWELL (International Council of Nurses), speaking at the invitation of the CHAIRMAN, said that universal health coverage of good quality required sufficient and motivated health workers of the right mix, located close to the point of delivery. She expressed concern that too much emphasis was being placed on financing and not enough on the critical shortage of health workers. Nurses were the largest group of health professionals, were closest to the population, and were often the only health professionals available to a population. Research had demonstrated that affordable nursing interventions could effectively contribute to the achievement of Millennium Development Goals and reduce the burden of noncommunicable diseases, including mental health disorders. The strengthening of primary health care services would be essential in order to reach the most vulnerable and marginalized members of society; nurses' roles therefore could not be ignored. The Health Assembly had repeatedly recognized that nurses and midwives were essential to the development of good-quality health policy and implementation of effective health interventions. However, the minimal reporting and inactivity of the Global Advisory Group on Nursing and Midwifery appeared to reflect a reduction in WHO's commitment to support the strengthening of nursing and midwifery globally. Universal health coverage could not be achieved without adequate numbers of appropriately trained nurses, and the involvement of nurses in policy-setting was essential. WHO and governments should ensure adequate pre- and post-registration education to invest in implementing evidence-based nursing interventions and to remove the regulatory barriers to the full integration of nurses in primary health care settings.

Ms SPELLER (Medicus Mundi Internationalis – International Organisation for Cooperation in Health Care), speaking at the invitation of the CHAIRMAN, expressed appreciation of WHO's efforts to tackle the problems of health-care impoverishment and financial barriers to health care access, but was uneasy about the use of the term "universal health coverage" rather than "universal health care". The history of global health policy-making had been characterized by poor choices of direction,

including the UNICEF policy of selective primary health care and the World Bank policy of promoting stratified health care, which had led to the vertical fragmentation of health systems. “Universal health coverage” had been adopted as an umbrella term, but was defined differently by a variety of global institutions, many of which were WHO donors. The World Bank, with which WHO collaborated closely on universal health coverage, had for many years promoted an inequitable system that assigned a prominent role to the private sector in health insurance and health-care delivery. The flaws in that model included the fact that stratified health care weakened social solidarity and the willingness of wealthier people to contribute to the cost of health care for all. Moreover, the regulation of costs, quality and over-servicing was much more difficult in the private sector; mixed health-care provision was associated with fragmentation and duplication in service development and delivery; and private-sector providers had a poor record in implementing the principles of primary health care and addressing the social determinants of health. She emphasized the importance of avoiding another false move in the history of global health policy-making.

Mrs BAUMGARTEN (The Save the Children Fund), speaking at the invitation of the CHAIRMAN, noted that innovations in health care achieved little if services were not of sufficiently high quality and the poorest people continued to be denied access. She commended the statement made by the World Bank Group President, Jim Yong Kim, at the fifth plenary meeting of the current Health Assembly,<sup>1</sup> in which he had acknowledged that even tiny out-of-pocket charges could have a detrimental effect on the uptake of health services by poor people, and that the elimination or sharp reduction of point-of-service payments was a common feature of all systems that had successfully achieved universal health coverage. His acknowledgement was significant because some had continued to advise governments erroneously that charging fees at the point of use was a good model that deterred unnecessary service use. Universal health coverage could be made fairer and more effective in reducing mortality and morbidity if governments established systems that legally required all to contribute according to their ability to pay, so that all could receive health care solely on the basis of their health needs. WHO and the World Bank had complementary roles to play in supporting the steps that Member States needed to take. However, universal health coverage was not the sole preserve of multilateral institutions: many governments were responding to public concerns by delivering health care as a right, not a privilege.

Dr WILEY (International Federation of Medical Students’ Associations), speaking at the invitation of the CHAIRMAN, noted with satisfaction the gathering momentum of global support for universal health coverage. Although she supported the current emphasis on financial risk protection as a key component of universal health coverage, she urged WHO to ensure that any definition of such coverage included the development of sustainable, equitable and fair health-care systems. Such systems must be dynamic, guarantee access to health care and give impetus to action on the social determinants of health. Universal health coverage must be based on three principles: achieving equity in health, which required a well-trained, equitably distributed health workforce; development of sustainable health systems designed to be adaptable and responsive to current and future challenges such as climate change, population growth, conflicts and emergencies; and attention to the social and health burdens faced by target groups, including minorities and at-risk populations. Universal health coverage and access were the means by which health as a human right and health equity could be realized.

Ms BENNETT (International Alliance of Patients’ Organizations), speaking at the invitation of the CHAIRMAN, said that WHO should develop a clearer definition of universal health coverage, one that included patient-centred health care and acknowledged the key principles of respect for the patient, choice and empowerment, patient involvement in health policy, access to safe, good-quality

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<sup>1</sup> See document A66/DIV./7.

and appropriate services and treatments, support for patients' needs, and information. She welcomed the inclusion in the global monitoring framework for the prevention and control of noncommunicable diseases of a target of 80% availability of the affordable basic technologies and essential medicines by 2025. The expansion of universal health coverage was an opportunity to build on WHO's progress towards ensuring access to essential medicines in all WHO strategies, including the post-2015 development agenda. Her organization would continue to support WHO and other interested stakeholders in their efforts to expand universal health coverage.

Dr KIENY (Assistant Director-General) thanked delegates and civil society representatives for their contributions to the debate, which had highlighted the need for universal health coverage to include interventions to ensure the attainment of the Millennium Development Goals, and to address the growing burden of noncommunicable diseases. Many speakers had noted that universal health coverage could not be achieved through the health sector alone: the involvement of other sectors and action on the social determinants of health would be critical. It had also been noted that universal health coverage meant more than health financing, and that interventions spanning promotion, prevention, treatment, rehabilitation and palliative care were required. In the area of promotion and prevention, population-focused action would be as important as interventions targeting individuals. Progress towards universal health coverage would require health system strengthening, with a strong emphasis on equity in the provision of quality health services, access to medicines and financial risk protection. Some Member States had requested the Secretariat to scale up its capacity in the area of health technology assessment and hospital management in order to provide them with better support in maintaining expenses within a reasonable range, and many speakers had stressed the importance of quality in medicines and health technology as well as in services, in a continuum across community, primary, secondary and tertiary care. Speakers had recognized the paramount importance of human resources for health, and some had pointed to the need to review existing national legislative and regulatory frameworks in order to promote progress towards universal health coverage and in particular the financing of services. She thanked the Republic of Korea for its offer of financial support and Brazil for its suggestion that the BRICS countries (Brazil, Russian Federation, India, China and South Africa) might identify experts to work with WHO on a monitoring framework for universal health coverage. The Secretariat was committed to continue working on universal health coverage with Member States, civil society and other United Nations agencies. A technical briefing would take place later that day to clarify the framework proposed by WHO for universal health coverage, and to share with delegates preliminary options for monitoring progress towards its achievement. On the basis of inputs from delegates, the Secretariat would continue to work with the World Bank with a view to proposing a more advanced version of the monitoring framework at the September 2013 session of the United Nations General Assembly.

The CHAIRMAN said that the informal drafting group that was considering the draft resolution proposed at the Committee's third meeting had indicated that it needed more time to conclude its work. She therefore took it that the Committee wished to adjourn its discussion of the item.

**It was so agreed.**

(For continuation of the discussion and approval of the draft resolution, see the summary record of the sixth meeting, section 2.)

**Substandard/spurious/falsely-labelled/falsified/counterfeit medical products:** Item 17.1 of the Agenda (Document A66/22)

Mr KLEIMAN (Brazil) thanked Dr Orjiako (Nigeria) for his competent work in chairing the first meeting of the Member State mechanism on substandard/spurious/falsely-labelled/falsified/counterfeit (SSFFC) medical products, and the Government of Argentina for having hosted the

meeting in Buenos Aires in November 2012. Throughout the intense negotiations on the falsification of medicines within WHO's governing bodies, Brazil had emphasized the importance of focusing on a public health perspective, and of excluding intellectual property or criminal considerations. He noted that in Buenos Aires a Steering Committee had been established to guide the mechanism and make it operational. The mechanism should strive to ensure the integrity of the supply chain of medicines and to improve the exchange of information between regulators; the differences that remained between Member States would be mitigated once the mechanism demonstrated its importance for public health. The starting point of the mechanism's work should be the identification of actions and behaviours that should be prevented and controlled, and he noted with satisfaction that Member States had agreed to establish the Open Ended Working Group for that purpose. He invited countries to contribute comments and suggestions in that regard so that the Group could meet no later than July 2013.

The Member State mechanism should operate in a fully transparent manner, from a public health standpoint, in accordance with its terms of reference.<sup>1</sup> He was concerned that other multilateral forums did not abide by those principles and sought to examine the matter from a criminal or enforcement perspective exclusively. The mechanism could usher in a new method of work within WHO in which Member States also had the responsibility of developing technical work. He urged Member States to reach agreement on the chairing of the mechanism so that it could begin its work as quickly as possible; he proposed rotation among the designated Vice-Chairpersons of the Steering Committee as a possible solution, and reiterated his delegation's suggestion that the mechanism should be designated as the "Buenos Aires Mechanism".

Dr ROZITA HALINA TUN HUSSEIN (Malaysia) expressed full support for the initiatives undertaken to achieve the objectives of the Member State mechanism on SSFFC medical products. She suggested that the Steering Committee should be constituted as a formal rather than an informal body so that its efforts could be coordinated more efficiently, and that meetings should be organized at regional level before the Steering Committee met so that suggestions or concerns from within regions could be conveyed to it by the appointed Vice-Chairperson. Malaysia was able to implement most of the actions listed in the workplan; it had an established regulatory framework and a workable medicine policy, and was willing to share its experience with others. She supported the suggestion that expert facilitators and other stakeholders should be invited to participate in the Member State mechanism as appropriate. Like many other countries, Malaysia faced a variety of problems in relation to the Internet marketing of medicinal products; the mechanism should devise a realistic action plan to tackle the matter in a coordinated manner. She supported the idea of obtaining a commitment from Member States' regulatory authorities to be transparent and willing to share vital information on the status of manufacturers and major players in the supply chain that were involved in cross-border movement of products, as that was vital to protect the integrity of global pharmaceutical industries.

Mr AL-SHEHABI (Bahrain) said that efforts relating to countering SSFFC medical products were designed to protect public health and patient safety. The manufacture, distribution and sale of such products were crimes that endangered human life and undermined the credibility of health systems. A comprehensive strategy must therefore be developed to tackle the problem in collaboration with partners at all levels. Emphasis must also be placed on the quality of health workers and on building their capacity to detect and prevent activities relating to SSFFC medical products, which must be reported, in particular in the event of patients failing to respond to treatment or experiencing unexpected side effects. The Secretariat had an important role to play in providing technical support that would enable Member States to identify gaps in their national legislation and to strengthen the capacities of their regulatory authorities. WHO should strengthen the global surveillance system in the interests of information exchange concerning incidents involving SSFFC medical products.

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<sup>1</sup> See resolution WHA65.19, Annex.

Ms MWAPE (Zambia), speaking on behalf of the Member States of the African Region, thanked Argentina and the Director-General for having hosted the first meeting of the Member State mechanism. One of the priority objectives for the African Region was to improve sustainable availability of and access to affordable, high-quality, safe and effective essential medical products. SSFFC medical products were a major public health concern, and the globalization of trade meant that no single country was immune to criminal activity involving such products, which was a threat to national and international security. The Member States of her Region therefore reaffirmed their commitment to the Member State mechanism, particularly considering that the largest share of SSFFC medical products was circulating in the Region's markets. She commended the work done so far to make the mechanism operational and develop the draft workplan, and supported the proposals on the mechanism's structure, governance and funding, including the functions of the Steering Committee. It was to be hoped that the question of the chairing of the Committee would be dealt with amicably and expeditiously in order to avoid undue delay. She reaffirmed the Region's support for the African candidacy for that post.

The elimination of SSFFC medical products was a top priority for the African Region, and its Member States would take an active role in the realization of the objectives of the Member State mechanism. The many challenges faced by countries in that regard included weak regulatory and enforcement systems, limited human resources for health, poor infrastructure to support the pharmaceutical supply chain, and inadequate financing for procurement of essential medicines and regulation. In collaboration with WHO, policies were being or had been developed to strengthen health systems including pharmaceutical services and medicines regulation both at national and regional level. However, there was no simple or standard solution to the problem and she therefore urged Member States to maintain their commitment to the Member State mechanism as a means of securing the integrity and security of the pharmaceutical supply chain.

The CHAIRMAN took note of the call for the question of the chairing of the Steering Committee to be resolved amicably and expeditiously.

Dr YUSUF (Nigeria) said that his country had established a plan to implement its revised national drug policies and national pharmaceutical goals. The manufacture of SSFFC medical products was widespread and had escalated to such an extent that effective international coordination and cooperation were needed to make regional and national strategies more effective. Nigeria had revised its anti-counterfeiting legislation to make the supply chain more secure, and as a deterrent to offenders; it had launched a new drug distribution guideline and a national pharmacovigilance policy, and was implementing innovative technologies to detect SSFFC medical products. The use of a message authentication service to determine the quality of medicines in retail outlets had been piloted and introduced. Nigeria had been the first country to deploy a handheld detection device at its borders and in retail outlets to detect SSFFC medical products; that capacity had since been extended to other countries in Africa and beyond. Nigeria was also the first country to have authorized a structured survey to determine the prevalence of SSFFC medical products, which had been conducted by WHO with support from the Department for International Development of the United Kingdom of Great Britain and Northern Ireland.

Given that a concerted international effort was essential, the establishment of the Member State mechanism was timely and appropriate, and he supported the clear recommendations made at the Buenos Aires meeting, including those on the draft workplan, the method of work and funding of the mechanism, and the establishment of the Steering Committee. The latter should be properly established and enabled to function as soon as possible.

Dr JAIN (India) said that India had consistently voiced concern over the use of the term "counterfeit" and had stressed the need for a common understanding of what was meant by SSFFC medical products. India had also objected strongly to any association of WHO with the activities of the International Medical Products Anti-Counterfeiting Taskforce (IMPACT). Furthermore, India had

participated in all Health Assembly debates on the subject, in both intergovernmental working groups in 2011 and in the new Member State mechanism in 2012. Medicines from India were exported to more than 200 countries, and vaccines to more than 150 countries, and many Indian manufacturing sites were currently approved by the United States Food and Drug Administration and the European Directorate for the Quality of Medicines. India had a robust drug regulation system, and the national regulatory authority of India and its affiliated institutions had been assessed by WHO against international benchmarks and indicators in December 2012, and had been found to be a functional regulatory system.

Noting with satisfaction that the Member State mechanism on SSFFC medical products had made considerable progress during its meeting in Buenos Aires in November 2012, he said that it was important to take forward the mechanism's activities in accordance with the established time frames, including the convening of a meeting of the Open Ended Working Group and the formal establishment of the Steering Committee. That work should be expedited and adequate resources should be harnessed for that purpose. He supported the proposal by the delegate of Brazil that the Steering Committee should have a rotating chairmanship.

Mr ÁLVAREZ LUCAS (Mexico) said that his country was committed to prohibiting any product of dubious quality that might jeopardize the health of its population, and had taken resolute action, pursuant to its support for paragraphs 2 and 6 of the workplan set out in Appendix 2 to the Annex to document A66/22, to identify medicines that might have adverse effects and cause confusion to health professionals. However, Mexico would not be in a position to comply with paragraph 8(b) of the workplan.

Ms SOSIALINE (Indonesia) said that her country fully supported the outcome of the Buenos Aires meeting and had high expectations that the Member State mechanism would lead international cooperation in the prevention and control of SSFFC medical products. Indonesia favoured the convening of a meeting of the Open Ended Working Group to follow up the discussion on the scope and areas of work of the mechanism on the basis of the proposals adopted at the Buenos Aires meeting. However, the question of the chairing of the Steering Committee should be resolved as quickly as possible to avoid further delay. She urged WHO to give priority to finding solutions for countering SSFFC medical products.

Ms BENNETT (Australia) said that SSFFC medical products were a serious public health and safety concern, and her country greatly appreciated the work of WHO in that area. Having participated in the first meeting of the Member State mechanism, Australia urged Member States to work in a spirit of cooperation to resolve outstanding issues, including the chairing of the Steering Committee, as quickly as possible so that the workplan could be finalized. Her delegation noted with interest and would give consideration to the name change for the mechanism proposed by the delegate of Brazil.

Mr RUSH (United Kingdom of Great Britain and Northern Ireland), speaking on behalf of the Member States of the European Region, regretted the slow pace of progress in the work of the Member State mechanism, which was reflected in the failure to reach agreement on various matters, including the finalization of the workplan and the appointment of a chairperson for the Steering Committee. Those developments had a negative impact on WHO's credibility as a serious protagonist in activities to counter SSFFC medical products. It was to be hoped that those early difficulties could be overcome swiftly and that the first meeting of the Open Ended Working Group would be convened in the near future, ideally in conjunction with the next meeting of the Steering Committee. In that context, he appealed to all Member States to send the appropriate technical experts to the Working Group, from which a positive outcome was to be expected within the time frame of two to six months, as initially envisaged. The Member States of the Region would continue to engage constructively in the proposed activities.



Speaking as the delegate of the United Kingdom of Great Britain and Northern Ireland, he added that the international alert issued by WHO the previous month with regard to the widespread distribution of falsified antimalarial drugs in western and central Africa served as a reminder of the need to make urgent progress in the area of SSFFC medical products.

Ms PATCHAREEWAN PHUNGNIL (Thailand) said that SSFFC medical products had a hugely negative impact on public health as they were a potential cause of treatment failure or even death, and contributed to increased drug resistance. Action to combat such products must focus on improved access to efficacious and high-quality medical products, and SSFFC medical products must be clearly defined so as to leave no room for confusion in relation to questions of intellectual property and trade. Interpretation of the definition must not threaten legitimate and good-quality generic medicines. Success in eliminating SSFFC medical products at the national, regional and global levels would depend on effective collaboration based on trust, and stakeholders must be free from conflict of interest. The increase in Internet sales and false claims relating to medical products in electronic media stimulated the entry of SSFFC medical products into the supply chain. Strong regulatory capacity and effective enforcement by national regulatory authorities were therefore essential. Furthermore, strengthening the existing SSFFC rapid alert system at all levels was an important instrument for consumer protection. Comprehensive action plans should be developed under the Member State mechanism, together with indicators to monitor and assess their implementation. Scheduled activities should be carried out in a timely manner. Following a technical consultation, a formal meeting of the Steering Committee should be held under the chairmanship of a person agreed on by all Member States. The Committee could then submit suggestions on the elements of the workplan to the Member State mechanism, for consideration at the latter's second meeting in November 2013. Members of the Steering Committee must be properly qualified, and the process of appointment should ensure transparency and freedom from conflicts of interest.

Mr JONES (Canada), noting that the Member State mechanism, at its first meeting, had displayed a strong commitment to combating the public health impacts of SSFFC medical products, urged the mechanism to focus on ensuring that Member States' collective efforts yielded tangible benefits in the prevention and control of such products. He supported the proposal of a rotating chairmanship in order to sustain momentum, and emphasized the importance of reaching agreement on the appointment as quickly as possible. He welcomed the proposal to convene an informal meeting of interested Member States following the adjournment of the first meeting of the Open Ended Working Group to consider the actions, activities and behaviours that resulted in SSFFC medical products and contribute to the development of a detailed workplan.

Mr ALEMNEH (Ethiopia) stressed the need for low-income countries to have access to technology for the rapid detection of SSFFC medical products. It was also important to use existing regional frameworks to combat the problem of SSFFC medical products.

Dr AL KALBANI (Oman) endorsed the functions of the Steering Committee of the Member State mechanism, as detailed in Appendix 1 to the Annex to the Secretariat's report (document A66/22), and the elements of the workplan set out in Appendix 2. Oman had taken positive steps to develop monitoring and enforcement guidelines in relation to the unethical promotion of medicines, as referred to in paragraph 6(f) of the workplan, and to adopt legislation aimed at limiting SSFFC medical products. More work was needed, however, to build the capacities of regulatory authorities and quality-control laboratories at the national and regional levels. Member States should pool their experience in those matters.

Mr SILLO (United Republic of Tanzania) commended the work done so far, but expressed concern that failure to decide the chairmanship of the Steering Committee had delayed the first steps

towards implementation of the workplan on SSFFC medical products that had been drafted in Buenos Aires. The matter should be resolved as soon as possible.

The system recently designed by WHO to report, record and analyse incidents concerning SSFFC medical products more accurately through the submission of rapid alerts by the national medicines regulatory authorities enabled countries to obtain a clearer and validated picture of what was taking place at country, regional and global level. The United Republic of Tanzania planned to host a regional training programme on the new system for national regulatory experts from eastern and southern African countries during the second half of 2013. The programme should assist African regulators in identifying products, trends and vulnerabilities, thereby facilitating deployment of resources, development of strategies and vigilance to combat SSFFC medical products. He reaffirmed his country's commitment to combating SSFFC medical products.

Dr VALDEZ (Philippines) said that the Philippines was a pilot country for the SSFFC medical product reporting project and was cooperating actively with WHO in that initiative. The Philippines hoped to provide recommendations with respect to paragraphs 6(f) and (g) of the workplan, on strengthening national and regional capacities in order to ensure the integrity of the supply chain. Adoption of a monitoring and enforcement system in respect of the unethical promotion of medicines and the disclosure of quality, safety and efficacy data for medical products would improve and further strengthen the identification and reporting of SSFFC medical products. In low- and middle-income countries, the need to strengthen access to good-quality, safe, efficacious and affordable medical products could be met by the use of generic medicines no longer covered by patents. However, generic medicines were also at risk from counterfeiting activities and would also require monitoring. She recommended that paragraph 8 of the workplan should be retained.

Mr WANG Zhexiong (China) said that SSFFC medical products were of international concern and China would therefore participate actively in the Member State mechanism, which should operate in accordance with WHO principles. However, SSFFC medical products should be covered by a more precise and widely accepted definition that was compatible with national laws. Activities under the Member State mechanism should be organized in a manner that enabled countries to exchange experiences and engage in joint projects. Information-sharing and coordination of investigative activities were particularly important in major cross-border cases. For countries with capacity requirements, it was important to coordinate international assistance and guidance to improve control and management of the supply chain. WHO-recommended criteria for appropriate law-enforcement equipment and technical support should also be established.

Dr SHOHANI (Iraq) said that the problem of SSFFC medical products must be addressed in national policies in order to guarantee medicine safety. In Iraq all pharmaceutical companies had to provide registration certificates for medicines, which must comply with standards in the country of origin. Samples of medical products were tested and no product was released for sale until established as fit for purpose in accordance with international standards. Efforts were under way to raise public awareness through the media and to exchange expertise with other countries in order to guarantee compliance with the highest manufacturing standards in the interests of safety. Partnership between the public and private health sectors was important for tackling compliance problems, as were stronger partnerships with civil society and international organizations, particularly WHO, for ensuring follow-up and producing reports on compliance and on companies responsible for counterfeiting.

Mr KOLKER (United States of America) said that the Member State mechanism provided an opportunity to work together to confront the issue of SSFFC medical products from a public health perspective, to build cooperation and trust, and to create an effective new method of work. However, the lack of consensus on the appointment of a chairperson for the mechanism was regrettable. He supported the view that the Health Assembly should recommend that the chairing of the Steering Committee should be rotated among the existing vice-chairpersons on an interim basis, pending

agreement on a workable solution at the next meeting of the mechanism. Flexibility on the part of Member States would be a prerequisite for progress in combating the global threat of SSFFC medical products, which would continue to increase in scope and complexity as long as no concrete action was taken.

Mr PIPPO (Argentina), speaking on behalf of the Union of South American Nations, said that public health should be the paramount consideration in combating SSFFC medical products. The establishment of the Member State mechanism was a fitting response to the global dimension of the problem, and required the support and commitment of all Member States. He commended the innovative organizational and governance structure established for the mechanism, which combined plenary meetings open to all Member States with a more executive structure in the form of the Steering Committee, on which the regions would be adequately represented. He noted with satisfaction that the Open Ended Working Group responsible for identifying the actions, activities and behaviours that resulted in SSFFC medical products would work to resolve the persistent questions of terminology that had proved an obstacle to progress. The meetings scheduled to be held in July 2013 should serve to ensure progress in the establishment of the Steering Committee and the formulation of the workplan, without hampering the continuity of work under the mechanism.

Speaking as the delegate of Argentina, he expressed support for the proposal of a rotating chairmanship for the Steering Committee and urged the Health Assembly to take a decision on the matter.

Ms LANTERI (Monaco) said that, in her capacity as a Vice-Chairperson of the Steering Committee, representing the European Region, she supported the proposal of an interim system of rotation of the chairmanship among the existing vice-chairpersons, as it was clear that the Steering Committee could not continue to function on an informal basis. Such a system would enable the Steering Committee to begin belatedly to meet the expectations of countries in need.

Dr TSECHKOVSKY (Russian Federation) said that SSFFC medical products were a transnational threat and that it was therefore important to develop specialized instruments to combat them. He supported the Secretariat's efforts to exchange information on cases involving SSFFC medical products and to develop a universal policy. The pilot global surveillance system designed by the Secretariat to inform Member States of potential threats represented an excellent opportunity to intensify efforts in that regard. Recognizing the importance of increased global collaboration on surveillance and monitoring, the Russian Federation had organized seminars for health-care workers in order to raise awareness of improved surveillance procedures.

Ms JAMEEL (Maldives) expressed support for all measures to ensure the availability of good-quality, safe, efficacious and affordable medical products and, in particular, resolution WHA65.19 which had established the Member State mechanism. She stressed the importance of strengthening national and regional capacities, and national and regional regulatory mechanisms to ensure the integrity of the supply chain. That was of particular relevance to Maldives where no formal capacity currently existed for the production of essential medicines, and ensuring the quality of imported medicines was of the utmost importance.

She called for greater cooperation and sharing of resources between Member States in order to strengthen national and regional capacity for medicine registration, quality control testing and surveillance of SSFFC medical products. The gaps in knowledge among public health professionals in relation to the consequences of such products must be addressed through greater advocacy among relevant stakeholders at the national level.

Dr NABEEL (Pakistan) said that he fully supported the work to combat SSFFC medical products, which was being taken forward by the Member State mechanism. However, consensus must be reached quickly on the appointment of a chairperson for the Steering Committee. In that

connection, the proposal by the delegate of Brazil was an interesting one and deserved consideration. The proposed workplan should be a focal point of discussion at the forthcoming meetings of the Open Ended Working Group and the Member State mechanism. Strengthening national and regional regulatory capacity was a central element of the workplan and must remain a priority.

Dr EL OAKLEY (Libya) expressed regret at the delay in electing a chairperson for the Steering Committee and welcomed the proposal made by the delegate of Brazil that the post should be rotated among the vice-chairpersons.

Ms HELA (South Africa) expressed appreciation of what had been accomplished at the first meeting of the Member State mechanism. However, she too was concerned at the delays and the lack of agreement on a suitable definition of SSFFC medical products. Quoting Albert Einstein, she said that problems could not be solved with the same thinking that had been used to create them.

Mr RUSH (United Kingdom of Great Britain and Northern Ireland) noted an emerging consensus on the idea of rotating the chairmanship of the Steering Committee, as proposed by the delegate of Brazil. He suggested that the Committee should move forward on that proposal.

Ms Li-Ling LIU (Chinese Taipei) said that several strategies had been adopted to combat SSFFC medical products in Chinese Taipei that had achieved positive results. Medicine production and distribution channels were monitored, an interdepartmental task force had been established, a public awareness-raising campaign had been implemented and an initiative had been launched to combat online sales of such products. Recognizing that international cooperation was an effective and essential way to tackle the issue, Chinese Taipei had, since 2012, participated in an Asia-Pacific Economic Cooperation project on medical product quality and supply-chain integrity.

Mr MWANGI (International Alliance of Patients' Organizations), speaking at the invitation of the CHAIRMAN, expressed support for the Member State mechanism and actions under the mechanism to strengthen and build the capacity of national and regional regulatory authorities and quality control laboratories. His organization also supported the commitment of Member States to communication, education and awareness-raising about SSFFC medical products among consumers, health professionals and industry. He encouraged Member States to build on the progress achieved in several of the areas outlined in the proposed workplan by the International Medical Products Anti-Counterfeiting Taskforce. The Member State mechanism should specify how the many stakeholders affected would be involved in combating SSFFC medical products, as a multi-stakeholder approach would be critical to success.

Mr OTTIGLIO (International Federation of Pharmaceutical Manufacturers and Associations), speaking at the invitation of the CHAIRMAN, expressed support for the work of the Member State mechanism and said that the new global agenda on SSFFC medical products must focus on patient safety. Counterfeiters did not discriminate: counterfeit versions of generic and branded medicines had entered the supply chain in both developed and developing countries and the Internet had served to facilitate trade in SSFFC medical products, many of which were sold from illegal sites that concealed their physical address. Experience had shown that a multi-stakeholder and multidisciplinary approach to combating SSFFC medical products would be required at the local and global level. His organization stood ready to play its part.

Ms PYZIK (International Pharmaceutical Students' Federation), speaking at the invitation of the CHAIRMAN, said that as the methods of criminals purveying SSFFC medical products became more sophisticated, it would become increasingly difficult and expensive to detect such products. There must therefore be no delay in taking action. She urged Member States to secure strong leadership and to implement the Member State mechanism workplan in full. Pharmacy students could also play a

useful role in helping to raise awareness of SSFFC medical products. Illegal Internet pharmacies were a dangerous and insidious phenomenon, and she called on Member States to develop a method whereby patients could verify the legitimacy of online pharmacies in countries where they legally existed. Further international cooperation was needed in the context of efforts to ensure patient safety.

Mr BESANÇON (International Pharmaceutical Federation), speaking at the invitation of the CHAIRMAN and on behalf of the World Medical Association and the International Council of Nurses, expressed strong support for WHO's work in ensuring the availability of good-quality, safe, efficacious and affordable medical products, and emphasized that measures taken to monitor and improve medicine quality were crucial not only for Member States but also for other United Nations organizations working to supply medicines to those in need. He therefore urged Member States to ensure the allocation of appropriate resources for those important activities. He expressed concern at the slow pace of implementation of the Member State mechanism, and in particular the delay in finalizing its terms of reference.

Dr KIENY (Assistant Director-General) said that many speakers had highlighted the importance of SSFFC medical products as a public health threat affecting all countries. Concerns had been raised about the appointment of a chairperson for the Steering Committee but a consensus appeared to have emerged on the proposal to rotate the chairmanship among the designated vice-chairpersons, on an interim basis, until the Member State mechanism held its next meeting in November 2013. Preparations were being made for that meeting and for the meeting of the Open Ended Working Group to be held in July 2013. Noting the many worthy actions taken by countries individually to combat SSFFC medical products, she emphasized that the mechanism had been established specifically to drive concerted international action on a problem that was international in nature. Looking forward to the next meeting of the Steering Committee, she said that the first steps were to be taken on implementation of the agreed parts of the workplan, those relating to strengthening regulatory authorities, raising awareness and information sharing. The full workplan would be finalized in due course.

The CHAIRMAN invited the Committee to consider the text of a draft decision concerning the chairing of the Steering Committee of the Member State mechanism, which read:

The Sixty-sixth World Health Assembly, having considered the report on substandard/spurious/falsely-labelled/falsified/counterfeit medical products, decided to recommend that the chairmanship of the Steering Committee of the Member State mechanism on substandard/spurious/falsely-labelled/falsified/counterfeit (SSFFC) medical products should operate on the basis of rotation, on an interim basis, without prejudice to the existing terms of reference of the mechanism.

**The draft decision was approved.<sup>1</sup>**

**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)

Dr VIROJ TANGCHAROENSATHIEN (Thailand), speaking in his capacity as Chairman of the open-ended meeting of Member States on the follow-up of the report of the Consultative Expert Working Group on Research and Development: Financing and Coordination, said that it formed part of an ongoing process under the global strategy and plan of action on public health, innovation and intellectual property. The outcome of the meeting held in November 2012 – the draft resolution

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<sup>1</sup> Transmitted to the Health Assembly in the Committee's third report and adopted as decision WHA66(10).

contained in the Appendix to document A66/23 – provided for a complex, stepwise process of implementation and reporting thereon. Two reports would be drafted in time for the Sixty-seventh World Health Assembly, one on the review of existing coordination mechanisms, as proposed in subparagraph 4(5) of the draft resolution, and the other on the evaluation of existing mechanisms for contributions to health R&D, as proposed in subparagraph 4(6). A further report would be prepared for the Sixty-eighth World Health Assembly on the implementation of health research and development demonstration projects, as proposed in subparagraph 4(4). Another open-ended meeting of Member States would be held prior to the Sixty-ninth World Health Assembly and would report to that Health Assembly on its findings.

He was confident of the viability of the concrete steps detailed in the draft resolution with regard to the development of national and global health research and development observatories for monitoring and identification of gaps as well as effective coordination and reviews of financing. He urged Member States to adopt the draft resolution and to implement its recommendations diligently.

Dr LIU Peilong (China) said that the importance of health research and development financing and coordination was recognized by all and was one of the items attracting the most attention from Member States at the current Health Assembly. He welcomed the draft resolution, which outlined actions that could be implemented immediately at the national and international levels to address the identified gaps disproportionately affecting developing countries. However, there was room for much further progress in implementing the recommendations contained in the report of the Consultative Expert Working Group, contained in document A65/24. Nevertheless, in a spirit of consensus, he was prepared to accept the draft resolution in its current form as an important opportunity to improve the coordination and financing of health research and development.

The report of the Consultative Expert Working Group stated that financing and coordination should build on existing structures whenever possible. He hoped that that guidance would be followed in setting up the health research and development observatory proposed in subparagraph 4(3) of the draft resolution and that observatories at the national and global levels would form an integrated network to monitor global health research and development. With regard to health research and development demonstration projects (subparagraph 4(4)), efforts should be directed not only at developing new medical products urgently needed by developing countries but also at determining health research and development needs and priorities, and ways to mobilize and allocate funds and de-link research and development costs from product prices. On the basis of such an approach, the demonstration projects should serve to develop evidence-based solutions of strategic importance for the long-term financing and coordination of global health research and development.

The draft resolution also requested the Director-General to facilitate the implementation of several health research and development projects through regional consultations and broad engagement with relevant stakeholders, and it would be useful to know whether the Secretariat had any concrete action plans to meet those requirements.

Dr JAIN (India) speaking on behalf of the Member States of the South-East Asia Region, said that the Region had engaged in national and regional consultations that had led to the adoption of resolution SEA/RC65/R3 by the Regional Committee for South-East Asia in November 2012, which had provided the basis for the draft resolution under discussion. The Regional Office for South-East Asia had recently initiated a study to take forward the work of the Regional Committee, with a view to prioritizing its activities, defining global norms and standards and identifying regional projects. The Consultative Expert Working Group had recommended the development of a binding convention, but the discussions at the open-ended meeting of Member States had fallen short of that commitment owing to Member States' differing views on matters such as the framework for the research and development treaty and global health research and development expenditure. The Member States of the Region called for continued discussion to find durable solutions for tackling the unmet health research and development needs of developing countries and to respond promptly to the remaining recommendations of the Consultative Expert Working Group's report.

Mr MAMACOS (United States of America) said that the consensus-based draft resolution before the Committee represented the best opportunity in decades to increase research and development for diseases disproportionately affecting developing countries, and should be adopted as drafted since market forces alone were not sufficient to generate the necessary investment. Member States should turn their attention to guiding the Secretariat in its next steps to implement the proposals, which included setting up a global observatory and developing research and development demonstration projects. For the sake of clarity on the path forward, he proposed supplementing the draft resolution with a draft decision that read:

Member States direct the WHO Secretariat to convene an advisory meeting including government representatives as well as, at the discretion of the Secretariat, technical experts from external stakeholders and the private sector, at the earliest possible date, in order to take forward action in relation to monitoring, coordination and financing for global health R&D, in accordance with the terms of resolution WHA66.XX. Such a meeting should particularly include members of the biomedical research community at a technical level and those currently involved in managing funds for research and development, with a mandate to (1) assist in the identification of translational research projects and the methodologies for coordinating research for the demonstration projects, in ways that emphasize the de-linkage of cost of R&D from product price and (2) identify ways to promote advocacy for identified R&D needs, and seek voluntary financing for the demonstration projects.

His Government could not undertake to allocate resources to a mechanism that was still not clearly defined and had no record of success. The proposed decision would help inform the research and development demonstration projects and would provide proof of concept. Noting the flexibility contained in subparagraph 4(7) of the draft resolution on the timing of a Member State meeting to be held prior to the Sixty-ninth World Health Assembly, he said that the United States of America would be open to convening such a meeting at an earlier rather than later date if the proposed advisory meeting and the Secretariat could demonstrate progress on a viable mechanism.

Dr ROHINGALAOU (Chad), speaking on behalf of the Member States of the African Region, said that the importance of global health research and development financing and coordination was highlighted by the provisions of resolution WHA65.22 requesting follow-up by the Secretariat. The Annex to document A66/23 showed that the follow-up process had been handled judiciously inasmuch as the open-ended meeting of Member States had benefited from the participation of research institutions, donors and other important actors. The tools at Member States' disposal in the open-ended meeting, including the results of national and regional consultations and reports from regional committees, the Consultative Expert Working Group and the Secretariat, were essential to thorough consideration of the various aspects of health research and development coordination and financing, and monitoring of expenditure. However, consensus could not yet be said to have been reached as the African Region's consultations had included only six of the Region's 46 Member States.

Developing countries had not hitherto received optimum financing for health research and development as allocations had been governed by market forces rather than needs, leading to exorbitant drug prices. Therefore, despite the financial and administrative constraints currently faced by many countries, there was an urgent need to set up a fund for the sustainable financing of health research and development. All existing funding mechanisms must be explored and, pending achievement of a consensus on a funding model, voluntary contributions could be made by Member States, donors and financial institutions to build capacity in developing countries and to ensure better coordination through the establishment of the observatory.

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, the Republic of Moldova, Armenia and Georgia aligned themselves with her statement. The proposed

draft resolution set out a clear strategy for financing and coordination of health research and development in line with the global strategy and plan of action on public health, innovation and intellectual property to which the European Union and its Member States were fully committed. The draft resolution not only provided a basis for a sustainable solution but allowed Member States and the Secretariat to take immediate action through a few demonstration projects. The evaluation of the projects would provide additional data that could be used to identify challenges relating to effective research and development coordination and financing mechanisms, with a view to ensuring a long-term, sustainable solution for health research and development.

She had noted and would study the draft decision proposed by the delegate of the United States of America.

Dr HORI (Japan), expressing support for the draft resolution, said that the current level of health research and development was insufficient to address diseases that disproportionately affected developing countries. In a bid to tackle the problem, his Government, in cooperation with Japanese pharmaceutical companies and the Bill & Melinda Gates Foundation, had established a public-private partnership mechanism, the Global Health Innovative Technology Fund. The Fund was a clear expression of his Government's commitment to promoting investment and facilitating health research and development. Japan would continue to play an active role in global health research and development by mobilizing its research capacity and extending its global partnerships.

Dr CLAURE (Plurinational State of Bolivia), speaking on behalf of the Union of South American Nations (UNASUR), said that the system of incentives for research and development based on patents had proved to be insufficient to meet the needs of developing countries. UNASUR therefore recognized the value of the report of the Consultative Expert Working Group on Research and Development: Financing and Coordination, and accepted its recommendations. The proposed establishment of an international research and development framework was the most appropriate structural solution to the problems identified. The proposal to create a global observatory was a positive initiative that would contribute to providing a regularly updated diagnosis of the research and development process. The proposed demonstration projects could usefully explore alternative models for the establishment of incentives, as long as they were in line with the principles and guidelines of the Consultative Expert Working Group. The de-linkage of research and development costs from the price of health products, the use of open and collaborative platforms for research and development and the acknowledgement of research and development and associated information as global public goods must form part of the guiding principles for project design. He underscored the need for consensus and continued dialogue among Member States, and expressed the willingness of the Union of South American Nations to work with the United States of America in order to reach consensus on the proposed draft decision.

Ms STIRØ (Norway) said that the report of the open-ended meeting provided a solid platform for joint action and represented a concrete step in developing the three interlinked areas of monitoring, coordination and financing of global health research and development. She fully supported the goal of ensuring that medical innovation and discoveries met the needs of developing countries. Since economic growth had raised many countries from low- to middle-income status, she looked forward to a more significant response to the call for increased financing from countries of the South.

The strategic workplan set out in the draft resolution provided a clear pathway for progress over the next few years, with a focus on the further elaboration and implementation of deliverables. As the Secretariat was required to report on the lessons learnt from the demonstration projects by 2015, no time must be lost in implementing the workplan. The aim should be to demonstrate positive progress while trying out new and different models, but projects must be designed to fit their designated time frame. She supported the draft resolution.



Mr AL RUBAE (Oman) supported the draft resolution. Oman was the second country in the Eastern Mediterranean Region to have held national consultations on matters relating to the report of the open-ended meeting of Member States on the follow-up of the report of the Consultative Expert Working Group on Research and Development: Financing and Coordination. The recommendations that had emerged from those consultations had been transmitted to the Secretariat. Oman was also working, with WHO guidance, to establish a health research observatory.

Ms SOSIALINE (Indonesia) said that current health research and development activities were inadequate to deal with various global health issues effectively, especially the diverse and complex health problems faced by developing countries. Greater investment, particularly in research and development focusing on diseases disproportionately affecting developing countries, would enhance innovative capacity in those countries and increase the amount of research undertaken and the number of medical products developed; it would also improve health outcomes. Capacity-building in and technology transfer to developing countries were also needed. Such action should be based on joint agendas and priority-setting related to developing countries' health needs and national plans for essential health research. Health research and development and access to health products should be strengthened through investment and sustainable collaboration. Such an approach was particularly important in relation to new drug research and attention should be paid to the de-linkage of research and development costs from the price of health products in developing countries. Lastly, she expressed support for the establishment of a global health research and development observatory.

Ms MATSOSO (South Africa) said that the 2012 report of the Consultative Expert Working Group on Research and Development: Financing and Coordination represented a milestone in a long-standing international effort to close the critical gaps in the development of drugs and other health technologies to meet the health needs of developing countries. She supported the draft resolution, which represented an important opportunity to address market failures through collective action, the pooling of resources and enhanced cooperation; it would create predictability and sustainability, and help to meet the needs of vulnerable populations.

She noted the comments made by the delegates of the United States of America and the Plurinational State of Bolivia and supported their proposals in principle. South Africa had increased its assessed contribution in support of the necessary preliminary work for the establishment of the global health observatory, which she hoped would begin without delay.

Ms JAMEEL (Maldives) commended the work of the open-ended meeting. The subsequent discussions at national and regional level would help to take forward the recommendations of the report of the Consultative Expert Working Group on Research and Development: Financing and Coordination. She emphasized the need for all health partners, including governments, academia, the private sector and nongovernmental organizations, to contribute to the proposed global health research and development observatory and to health research and development financing and coordination mechanisms, especially in support of developing countries. Some countries, including her own, had very limited health research and development capacity; it was therefore imperative for them to build partnerships with regional research centres.

**The meeting rose at 12:25.**

## **FIFTH MEETING**

**Friday, 24 May 2013, at 14:40**

**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)

**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)

Mr PIPPO (Argentina) said that the main mechanisms generating incentives to promote research and development were based on competitive systems aimed at securing a monopoly income. When the expected value of that income was insufficiently attractive, commercial interest evaporated, leading to gaps in research and a lack of medicines. The draft resolution before the Committee reflected the consensus that had emerged from long and difficult discussions, and represented a useful step forward. Nonetheless, his delegation supported the position expressed on behalf of the Union of South American Nations that consensus was incomplete. Although progress had been made on setting up the observatory and promoting projects, further dialogue was needed in order to find a sustainable solution to the question of financing. He had noted the draft decision proposed by the delegate of the United States of America: if the draft resolution was adopted without amendment, it should be emphasized that the meeting proposed in the draft decision should be regarded as separate from that mentioned in subparagraph 4(7) of the draft resolution.

Ms CHEDEVILLE-MURRAY (France) supported the draft resolution. It provided a suitable framework for tackling the financing and coordination of research, particularly with regard to developing countries, but it did not settle every issue. France had made a commitment to provide support to the Secretariat in order to make progress, in particular in the establishment of the observatory. She also supported the draft decision proposed by the delegate of the United States of America; the suggested process would advance matters. She asked whether the technical experts from external stakeholders referred to could include experts from civil society and nongovernmental organizations and, whether the conclusions of the proposed meeting would then be considered and, if necessary, decided upon by the WHO governing bodies.

Ms VACA GONZALEZ (Colombia) said that her country had been pleased to participate in the discussions that had given rise to the draft resolution under consideration. During that 10-year process, enormous efforts had been made to agree on proposals that would close the gaps in the current model of innovation for health technologies. She recognized that the report of the Consultative Expert Working Group, the draft resolution and the proposal put forward by the United States of America all represented progress in that regard. Member States now had the opportunity to act, so that in the near future research and development incentives and the resulting innovations would respond to the health needs of most of the world's population. Colombia was committed to seeking and implementing specific solutions to the outstanding matters mentioned in the report and the draft resolution. She agreed that there should be discussions by governments and academics before the Sixty-ninth World

Health Assembly in order to clarify the current difficulties in innovation and suggest initiatives for the monitoring, coordination and financing of research and development.

The national development plan in Colombia had established the relevance of science, technology and innovation in the health field, and the Government had earmarked a significant percentage of resources derived from mining fees for health research projects. There was a national commitment to the mandate of the Health Assembly, as it provided an important opportunity to bring about coherence between national and global public policies with a view to taking up the challenge of universal health coverage that all countries had discussed fully during the session. Innovation was part of efforts to secure well-being and prosperity: it led to well-being when it was directed towards solving health problems that were relevant to countries, regardless of income; and it could create prosperity if it also facilitated measurable, simple and high-impact solutions that were consistent with promotion of the rational use of, and equal access to, technologies.

Mr KIM Young-hak (Republic of Korea) asserted that, in order to ensure that research and development met the health needs of developing countries, it was essential to expand international collaboration and joint research, and to build a network linking businesses and research institutes. During the discussions that had led to the draft resolution, agreement had been reached mainly on the monitoring of resources and information-sharing. Member States had differed in their views on the development of a convention on financing and coordination. The Secretariat should conduct a thorough feasibility study and examine implementation strategies before considering a global convention on health research and development.

Mr VON KESSEL (Switzerland) recognized the lack of investment in research and development on diseases that disproportionately affected developing countries, and backed the establishment of a global observatory that would improve the monitoring of resource flows and identify research and development gaps. The process should be implemented in stages, and the draft resolution under discussion was an important step. Development of demonstration projects would provide added value for continuation of the process and enable coordination and financing models to be assessed. Those projects should be used to implement the key principles and approaches described in the report and should build on existing structures to ensure rapid results. Models such as the Drugs for Neglected Diseases initiative and the Medicines for Malaria Venture were good examples that had proved successful and could provide inspiration. In that connection, Switzerland had decided to double its financial support to the Drugs for Neglected Diseases initiative for 2013 and considered that priority should be given to neglected diseases urgently requiring treatments, focusing initially on projects needing additional financial support for the final clinical trial phases, in order to speed up approval. In the longer term, less advanced projects should also receive financial support and be included in the global coordination process. By 2016, the chosen model must be shown to work by attracting donors and advancing selected research projects. Given its large pharmaceuticals industry and world-renowned public health, medical research and medicine approval institutions, it was important for Switzerland to find synergies and establish dialogue among the various players at the national and international levels, in order to guide and support research into solutions for neglected diseases. He was in favour of adopting the draft resolution without amendment.

Mr JONES (Canada) agreed that inadequate monitoring of research and development spending was a barrier to the coordination of efforts among research networks and funders; the global observatory was a robust solution. He supported the draft resolution and agreed with previous speakers that it was important to demonstrate concrete progress. He supported the convening by the WHO Secretariat of an advisory meeting of government representatives and technical experts to identify research projects, methodologies for coordination and ways of promoting advocacy for identified research and development needs as called for in the draft decision proposed by the delegate of the United States of America. Those were areas of critical importance that required further guidance.

Dr JUAN LÓPEZ (Mexico) reiterated her country's interest in all parts of the research and development agenda, particularly the attention to diseases that disproportionately affected the poorest countries. She commended the joint efforts of Member States that had resulted in the draft resolution now before them, which she firmly supported.

Dr SHOHANI (Iraq) said that it was imperative to progress towards new implementation mechanisms. In developing countries there was an urgent need for expansion of research and development, especially with respect to public health.

Ms HARB (Lebanon) urged adoption of the draft resolution because monitoring, financing and coordination of health research development were crucial to universal health coverage with affordable, good-quality medicines and health technologies where most needed. Establishing a global health research and development observatory and capacity-building for research institutions were of particular importance. She endorsed the view expressed by the delegate of China at the previous meeting that there could have been greater progress on the Consultative Expert Working Group's recommendations, but she nonetheless welcomed the draft resolution as part of a stepwise approach.

Dr MALECELA (United Republic of Tanzania) said that the draft resolution was the result of a hard-won consensus and a stepwise approach, and, if implemented, in particular with the establishment of a global observatory, would represent real progress. Although further dialogue was needed, a start could be made immediately. In the current focus on process, however, Member States should not forget outcomes, which must include more health products to combat the diseases of developing countries that disproportionately affected the poorest of poor people, through increased investment in health research and development, and improved coordination. Moreover, demonstration projects should be implemented with a view to subsequent scaling up. She supported adoption of the draft resolution without amendment and was willing to consider the draft decision proposed by the United States of America.

Dr MUTAMBU (Zimbabwe) appreciated the three key activities proposed in the draft resolution. However, a number of questions raised in the report of the Consultative Expert Working Group had not been resolved, and she therefore recommended that another open-ended meeting of Member States be held in 2014, rather than in 2016 as proposed.

Ms Jie-Ru TZENG (Chinese Taipei), commending the endeavours of the Consultative Expert Working Group, supported the setting of goals related to the global strategy and plan of action on public health, innovation and intellectual property. Improvements in monitoring, coordination and priority-setting in order to ensure sustainable funding for health research and development on Type I, II, and III diseases in developing countries would contribute to a fairer, healthier and more sustainable global society. Chinese Taipei recognized the need to promote capacity-building and technology transfer, as well as investment in health research and development, for diseases disproportionately affecting developing countries, as set out in the draft resolution. It therefore stood ready to work with the international community to share its health research technologies, achievements and experiences with developing countries, and to provide training and funding. A healthy and sustainable global health system required the participation of all members of the international community, together with the contributions of capable partners.

Mr EDWARDS (Council on Health Research for Development), speaking at the invitation of the CHAIRMAN, endorsed the call for the establishment of a global health observatory. However, such an endeavour could not simply be a supranational process; monitoring capacity must also be built from the bottom up. Countries would require support in mapping national research and development resources to enable them to assess whether those resources accorded with their priorities, and in identifying opportunities for strengthening national research management capacity. Moreover,

Member States would need to provide comprehensive and sustainable financing in order to avoid the risk of failure.

With regard to coordination, the report of the Consultative Expert Working Group had stressed the importance of supporting country-led research agendas. When a priority-setting process was designed at the global level, country agendas must be recognized and incorporated into the process, thereby increasing its legitimacy.

The observatory, the global priority-setting process and the demonstration projects would not materialize without financial commitment by Member States. The demonstration projects should incorporate the principle of de-linking the cost of research from the prices of the products, and should support the other principles outlined in the report, including strengthening the sustainability of research and development through capacity-building. The projects should move forward, rather than delay, the multilateral process. The criteria for judging their success should be their ability to test alternative funding models and incentives. There was no need for low- and middle-income Member States to wait until 2016 to take action on research and development financing. Their governments must continue to invest more in research and innovation, to reach out to like-minded neighbours, to form a consortium, and to create their own development fund for health research and development needs.

Mr OTTIGLIO (International Federation of Pharmaceutical Manufacturers and Associations), speaking at the invitation of the CHAIRMAN, said that the consensus reached at the end of the open-ended meeting showed Member States' long-term commitment to comprehensive action and to delivering tangible results. He welcomed the idea of undertaking a systematic and standardized global review of unmet needs for health research and development related to Type II and Type III diseases, and of resource flows and research capacity. Understanding key research gaps was a precondition to addressing them, and the establishment of an observatory would offer a prime opportunity for achieving that goal. Members of his organization were continuing their engagement. A recent status report showed that research and development projects on the diseases concerned had risen by 40% in 2012 compared with the previous year. Moreover, 85% of those projects had been carried out through collaborative approaches. There was also an opportunity to work through existing initiatives, such as WHO's Special Programme for Research and Training in Tropical Diseases and WIPO's Re:Search initiative, and to learn from positive examples such as the recently established Global Health Innovative Technology Fund. His organization and its members were ready to provide expertise and further assistance in the process.

Mrs FABBRI (Medicus Mundi International – International Organisation for Cooperation in Health Care), speaking at the invitation of the CHAIRMAN, commended the efforts made in developing the global strategy and plan of action. The draft resolution gave rise to some concerns, however, in particular with regard to the establishment of an observatory and the implementation of health research and development demonstration projects. The projects should be consistent with the principles outlined in the global strategy and plan of action and in the report of the Consultative Expert Working Group, including those of open innovation and de-linking the costs of innovation from the price of health products. Moreover, the terms of engagement with private for-profit entities should be clarified, so as to avoid replicating the current framework for conducting research, which was based on the principles of intellectual property.

While the actions proposed in the draft resolution represented small steps forward, fundamental changes in the innovative activity concerning health products required more decisive and bolder measures. Systems should favour human lives over patents and profits. A decade after the establishment of the Commission on Intellectual Property Rights, Innovation and Public Health to stimulate new research and development models that would address the unmet needs for new products, real action was still lacking. The global strategy and plan of action had constructed a roadmap to redeem the promise of the Commission's report. At the heart of its recommendations was the call to begin discussions on a global research and development convention. She was disheartened that the

proposed resolution fell far short of expectations by postponing consideration of such a convention, and urged Member States to set an early date for the initiation of discussions thereon.

Ms ATHERSUCH (MSF International), speaking at the invitation of the CHAIRMAN, recalled that her organization had welcomed the analysis and recommendations of the Consultative Expert Working Group, including the central recommendation that Member States should start formal negotiations on a research and development convention, as its field teams bore witness to the fact that the current innovation model was failing. There were still gaps where financial incentives were insufficient to encourage research and development and products were often priced out of reach. Innovation models should accord with health needs and should result in medical innovations that were affordable and accessible to all.

The operative part of the draft resolution appeared to lack ambition and precise definition. Despite the clear recommendations of the Working Group's report, WHO-level discussions on a global research and development convention were not scheduled until 2016, showing a failure to connect with recognition of the scale and urgency of the problem. The draft resolution proposed just three concrete actions. Those elements were important, and it was critical to ensure that they were designed and implemented in a way that built on the Working Group's conclusions. The work should be guided by the principles of innovation with access. Member States should show political will and ensure that technical and financial resources were provided to drive the proposals forward in a meaningful way. The draft resolution before the Committee was simply the starting point. Although the medium-term framework of the global strategy and plan of action was due to end in 2015, much of its ambition remained unfulfilled. Member States should consider the longer-term framework that would be needed to ensure affordable, needs-driven innovation, and meaningful negotiations on financing, coordination and the agreement of global norms should follow. In respect of the proposal from the United States of America, she said that it was important to learn from past mistakes and to institute a Member State-led process for the selection of technical experts, in order to ensure transparency.

Ms RASMUSSEN (International Federation of Medical Students' Associations), speaking at the invitation of the CHAIRMAN, said that the health needs of neglected populations could not be met unless Member States embraced a new research and development paradigm, in which the cost of drug development and product price were no longer linked. A commitment to innovative research and development models that yielded global public goods would benefit all countries, low-, middle- and high-income alike. A robust global health research and development observatory was needed with real monitoring, priority-setting and coordination capacities. She called for leadership from the WHO Secretariat and strong engagement and financing from Member States, to ensure that the observatory was not understaffed or underfunded, and that it genuinely advanced global understanding of critical research and development needs. Demonstration projects should be substantial and well financed. Open-source collaboration could spur more expansive and efficient research and development; the resulting innovations should be openly licensed for competitive, affordable production as global public goods. With regard to the proposed advisory meeting, Member States should reserve the right to propose and select advisers, who should represent a wide range of innovative thinkers and civil society actors. The advisory group should not be limited to establishment stakeholders that might have financial or political conflicts of interest regarding the maintenance of flawed elements of current innovation models.

Ms MELLEMA (Stichting Health Action International), speaking at the invitation of the CHAIRMAN, recalled that the report of the Consultative Expert Working Group had expressed the urgent need to repair a broken research and development system with a comprehensive solution in the form of a global framework. However, the draft resolution did not provide a clear agenda towards that goal, and suffered from lack of ambition, clarity and concrete commitments. It did, however, contain some valuable elements that could be used as stepping stones. She welcomed the commitment to a

health research and development observatory and the demonstration projects. Nonetheless, she was concerned that the core principles and norms that should govern public health research and development were being lost sight of. Projects should advance work on those principles and norms, otherwise the subsequent process would risk being reduced to a weak coordination mechanism that put little money into an existing system that was failing. The demonstration projects should be used to harness the “push and pull” mechanisms that, according to the Working Group, best incorporated the principles of de-linkage and knowledge sharing. The proposed observatory should identify and provide guidance on the priority areas of needs-driven research and development, and data should, as far as possible and appropriate, be publicly accessible. The observatory should collect economic, legal scientific and health impact data on research and development spending by both State and non-State actors, but it could even be more ambitious and also collect actual research data. Given the urgency of the situation, she called on Member States to begin discussions on a framework for coordination, norm-setting and financing for health research and development in 2014. With regard to the proposal by the delegate of the United States of America, she said that it was important to avoid repeating mistakes, and any advisory group should be either consultative with governments or intergovernmental. When other stakeholders were involved, they should include civil society.

Dr KIENY (Assistant Director-General) thanked delegates and civil society representatives for their helpful and positive comments and assured the Committee that preliminary work was already under way.

The CHAIRMAN observed that during the discussion there had been significant consensus around support for the draft resolution without amendment, but the United States of America had tabled a draft decision, which had been circulated, and a number of delegates had referred to it in their interventions. She suggested that the Committee should examine the draft decision to clarify the text before proceeding to formal consideration of the draft resolution and subsequently the draft decision.

**It was so agreed.**

Dr ONDARI (Secretary) read out the text of the proposed draft decision, which read:

Member States direct the WHO Secretariat to convene an advisory meeting including government representatives as well as, at the discretion of the Secretariat, technical experts from external stakeholders and the private sector, at the earliest possible date, in order to take forward action in relation to monitoring, coordination and financing for health R&D, in accordance with the terms of Resolution A66/XX. Such a meeting should particularly include members of the biomedical research community at a technical level and those currently involved in managing funds for research and development, with a mandate to (1) assist in the identification of translational research projects and the methodologies for coordinating research for the demonstration projects, in ways that emphasize the de-linkage of cost of R&D from product price; and (2) identify ways to promote advocacy for identified R&D needs, and seek voluntary financing for the demonstration projects.

Mr MAMACOS (United States of America) said that he had had further discussions with some delegates and that those of Ecuador and Argentina had proposed minor amendments to the text that did not change the substance significantly. Concerning the two points in the draft decision on which France had asked for clarification, he said that the technical experts from external stakeholders referred to should indeed include experts from civil society, and that the conclusions of the meeting would be reviewed by WHO’s governing bodies. The word “advisory” had been intended to imply exactly that, and the meeting would not have any decision-making powers. The question of how “outside experts” should be defined was tricky, however. The idea was that it would be a technical meeting and therefore should be small.

The CHAIRMAN asked the delegate of the United States of America for details of the proposed amendments to the draft decision. He had said they did not affect the substance, but the Committee needed to see them in order to decide.

Miss PATCHAREEWAN PHUNGNIL (Thailand) welcomed the draft decision submitted by the delegate of the United States of America but proposed two amendments: deleting from the first sentence the words “as well as at the discretion of the Secretariat” and, in the second sentence, in point (1) after “translational research projects” adding the words “with high potential of success”, and in point (2) replacing the word “identified” with the word “priority”.

Mr ROSALES LOZADA (Plurinational State of Bolivia) thanked the delegate of the United States of America for seeking to build bridges between the various positions. He welcomed the suggestion of holding a meeting led by Member States but also attended by other interested groups, including researchers and people involved in biomedical research, and supported the proposed timing. The Union of South American Nations had problems with some of the language, however, a concern shared by most of the other Member States with which he had discussed the matter. In particular, he believed the reference to membership of the meeting being at the discretion of the Secretariat needed rewording. Furthermore, he proposed that the text should be amended by inserting the words “and sustainable” after the word “voluntary” in point (2).

Dr AL KALBANI (Oman) suggested displaying the text of the draft decision on an overhead projection to make it easier to see and discuss.

Ms HAGERTY (Ireland), speaking on behalf of the European Union, thanked the delegate of the United States of America for the proposed wording. She suggested that consideration should be given to deleting the word “translational” in point (1) of the proposed mandate, so that the proposed meeting could consider all appropriate potential projects.

Ms MATSOSO (South Africa) welcomed efforts to make progress, in particular the draft decision. The text of the draft decision required further refinement, however, to consolidate references to each of the three components: membership, projects, and subsequent action on identified projects. She agreed with other speakers that the wording concerning projects was too restrictive and proposed that the word “translational” should be deleted. She questioned the use of the word “advocacy” in point (2): in earlier discussions, the talk had been of setting priorities, and she considered that “advocacy” represented a watering down of that approach.

Mr PIPPO (Argentina) endorsed the observations made by the delegate of the Plurinational State of Bolivia. He proposed that the draft decision should be amended to refer to conflicts of interest in relation to the participation of other interested groups, and supported the proposed deletion of the word “translational” in point (1).

Ms HARB (Lebanon) expressed concern that the current wording of point (2) might jeopardize financing and proposed that the text be amended by replacing the words “voluntary” with the words “sustainable financing, including voluntary”.

The CHAIRMAN suggested the establishment of an informal group of interested Member States, chaired by Ms Matsoso (South Africa), to refine the text of the draft decision further, and took it that the Committee would wish to adjourn the discussion of item 17.2 until the group had concluded its work.

**It was so agreed.**



(For continuation of the discussion and approval of the draft resolution and the draft decision, see the summary record of the sixth meeting, section 2.)

**The health workforce: advances in responding to shortages and migration, and in preparing for emerging needs:** Item 17.4 of the Agenda (Document A66/25)

Mr ABDALLAH QASEM (Jordan) said that in the light of the shortcomings revealed in document A66/25 concerning the response to requirements under the WHO Global Code of Practice on the International Recruitment of Health Personnel, it would be necessary either to review the mechanisms for implementation of the Code or to investigate the reasons for those shortcomings, in order to clarify matters. Commitment to the Global Code should be reaffirmed in view of the tremendous impact it had on public health, particularly in developing countries.

Mr KOUYATE (Burkina Faso), speaking on behalf of the Member States of the African Region, said that the review of the implementation of three resolutions (WHA63.16, WHA64.6 and WHA64.7) relating to the health workforce had shown that little progress had been made. The advance towards universal health coverage would require the integration of health workforce planning, policy development and overall strengthening of health systems. The roadmap for scaling up the health workforce, adopted by the Regional Committee for Africa at its sixty-second session, encouraged collaboration between Member States, the African Union, the Global Health Workforce Alliance and development partners in drawing up and implementing detailed health personnel plans that focused on reducing the effects of migration, increasing production and devising mechanisms for retaining health personnel. All Member States should implement the three resolutions mentioned in the report, and the Director-General should support them in doing so.

Professor SUCHITTRA LUANGAMORNERT (Thailand) noted that the WHO Global Code of Practice, despite being voluntary, had been implemented by a number of Member States, particularly in the European Region. There was nonetheless a great deal of room for improvement, notably in designating national focal points and increasing the number of reporting countries. Although international migration of the health workforce was not a major problem for Thailand, the country complied fully with the Code. The recruitment of foreign nurses and midwives from countries with a critical shortage of health personnel was strongly discouraged. As a response to a significant increase in demand for health services, Thailand had increased the numbers of health personnel trained and had implemented several effective retention strategies, including financial and non-financial incentives. Thailand gave support to neighbouring countries by training nurse educators, who then returned to their countries. Much could be learned from the European Union's experience of regional cooperation: it would be useful to replicate European practices in the Asia-Pacific region and ASEAN. Collaboration among key stakeholders within countries was also essential. Working together across sectors and professions as a team with patient-centred education and services would ensure holistic education and health systems. Education systems for human resources for health should be revised accordingly. A global movement on reforming health workforce education was under way and the Health Assembly was considering a draft resolution on the subject. She looked forward to seeing greater commitment to the WHO Global Code of Practice through effective implementation and reporting on its impact over the three years ahead.

Dr SWANN (Bahamas) said that the member countries of the Caribbean Community had generally incorporated the WHO Global Code of Practice into their recruitment and retention policies. Faced with the challenge of health workers migrating from the Caribbean region to more developed areas, those countries needed to build health sector capacity; plan and train for attrition; mitigate "push" factors, such as by increasing job satisfaction; and train sufficient people to meet national needs. Adequate health workforce numbers and competencies were prerequisites for the successful implementation of universal health coverage. Health ministries in countries throughout the Caribbean

were therefore working with stakeholders, tertiary education institutions and regulatory bodies to develop and implement appropriate health workforce strategies. He urged the larger international bodies to be mindful of the detrimental effect that recruitment practices could have on human resources for health in the Caribbean region.

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, the Republic of Moldova and Armenia aligned themselves with her statement. A well-trained health workforce was one of the main pillars of a sustainable health system capable of achieving universal health coverage: the lack of health personnel represented the principal constraint on quality and coverage in low-income countries. The European Commission had therefore approved an action plan covering skills required, recruitment and workforce planning. A European Union joint action plan on workforce planning and forecasting had been launched in April 2013, which brought together some 50 partners from health ministries, public health institutes and professional organizations, many of which were connected to institutions in low-income countries.

The economic crisis had exacerbated the strain on health systems, and health workforce shortages had prompted an increase in the cross-border recruitment of health professionals. National policies, intersectoral structures and measures that included health workforce planning, distribution, retention and training were the key to providing sustainable health workforces. Steps should be taken to avoid overloading scarce human resources by duplication of tasks, poor integration of services, underuse of the skilled health workforce and diversion of highly specialized resources away from their specific skill sets. In the European Region, 80% of Member States had designated a national authority in accordance with the WHO Global Code of Practice; other Member States should endeavour to do the same. As the health workforce crisis was global and multidimensional, more efforts should be made to implement the Code. Reporting was of crucial importance for following up implementation, and the Secretariat was therefore requested to give Member States guidance and support with the necessary monitoring.

Dr WIDIYARTI (Indonesia) said that the key to success was to strengthen commitment and collaboration among stakeholders, including international agencies and professional organizations, in order to mobilize resources together and to implement a comprehensive health workforce plan in accordance with the role and function of each stakeholder. Indonesia had drawn up a human resources for health development plan for the period 2011–2025 using the country coordination and facilitation approach. The plan was expected to mobilize support from all stakeholders in relation to information systems, assessment of requirements, recruitment, distribution, incentive schemes to improve rural retention, pre-service and in-service training, continuing medical education, migration and quality control.

Indonesia was trying to speed up attainment of the Millennium Development Goals and was looking beyond them, but those efforts would require adequate support by a qualified health workforce. Nurses and midwives played critical roles as front-line personnel, working closely with the community at village level, and additional training of such persons in remote areas where there were no physicians available would help to save more lives. More than 30 000 new nurses were trained each year and there was a limit to the extent to which they could be absorbed into the Indonesian market. As a “sending country”, Indonesia planned to adopt the WHO Global Code of Practice into national legislation as a means of controlling internal and external migration. The country had already designated a national authority responsible for implementation of the Code; sent its first monitoring report to WHO; and translated the Code into Indonesia’s national language and distributed it to key stakeholders for further implementation. She suggested that all “destination countries” should also commit themselves to adopting the Code.

Mr TEGENE (Ethiopia) said that his country was implementing programmes to train large numbers of health professionals but such programmes required integrated support from the

Government, development partners, civil society and professional associations. He called on the Secretariat to facilitate collaboration between teaching institutions in different Member States. Countries that received health professionals who had migrated from developing countries had a moral obligation to support those in which they had been trained.

Mr DEANE (Barbados) asked what reasons lay behind the worryingly low number of reports submitted by Member States. He noted the lack of harmonization between the demand and supply of health professionals in the private and public sectors, a situation that did not facilitate workforce planning and projection of trends. Most countries already had systems for registering the health workforce, and so arguably something more substantial was required. In view of the role played by human resources in delivering health care, and given the drive towards universal health coverage, he urged the Secretariat to provide more guidance on the establishment of human resource observatories, workforce planning and research mechanisms.

Ms GIBB (United States of America) said that her country supported the goals of the WHO Global Code of Practice and had submitted its report in 2012. However, few other countries had designated a national authority to implement the Code and even fewer had submitted a national report. The Secretariat should investigate the barriers that Member States had faced and then provide technical guidance on improving data collection strategies. In addition, the national reporting instrument should be more refined; in its current form it was too broad and general to monitor migratory trends.

In the United States of America, medical and nursing school enrolment had been increased and health workforce programmes were being carried out to reduce the “pull” factors for health worker migration; they had already led to a drop in the migration of physicians and nurses. Similarly, a national centre for health workforce analysis had been set up to assess current and future health workforce supply and demand and to inform the public and private sectors of the country’s recruitment needs.

Internationally, the President’s Emergency Plan for AIDS Relief, the Peace Corps and other health-related development assistance continued to increase the pool of trained professionals and support training opportunities worldwide, especially in Africa. Moreover, in the first few days of the current Health Assembly, the United States of America had sponsored a side event with African colleagues on the Plan’s Medical and Nursing Education Partnership Initiatives, which were dedicated to increasing educational capacity for training health care workers in sub-Saharan Africa.

Ms JAMEEL (Maldives), noting the importance of the WHO Global Code of Practice, said that there was a critical need for long-term health workforce plans and for more data on the health workforce at the national and international levels. More than 80% of health system personnel in Maldives were expatriates, but the turnover rate of expatriate physicians was so high that it was difficult to train and orient them towards national health needs. The resulting frequent service disruptions and negative impact on quality of care hampered efforts to achieve universal health coverage. Health workforce regulatory systems should be improved, with greater collaboration between governments and regulatory authorities. Nurses and community health workers played crucial roles in health promotion and disease prevention, especially in remote areas; it was important to strengthen those categories of personnel, to reduce dependence on expatriates, sustain services and progress towards universal health coverage. Given its lack of medical colleges and limited capacity for training health care workers, Maldives called on the Secretariat to continue supporting efforts to build national capacity and seek innovative solutions to the health workforce crisis.

Ms SORDAT (Switzerland) said that the WHO Global Code of Practice, a major success story of the Sixty-third World Health Assembly, was one of the Organization’s most important instruments. Switzerland had submitted its first annual report in 2012 and, in cooperation with Germany and Austria, had translated the Code into German. The news that only approximately 50 countries had

submitted reports was somewhat worrying, especially considering that 36 of them were from the European Region, and also that one of the Code's main strengths was the monitoring mechanism designed to ensure its implementation. In preparation for the next round of national reports due in 2015, it would be sensible to consider the reasons for the low response, as the delegate of the United States of America had suggested, and to contemplate possible amendments, particularly regarding the questionnaire format and the involvement of civil society in the exercise.

Since the adoption of the Code, attention to health workforce migration seemed to have declined at WHO headquarters, and the responsible unit had been restructured and reduced in size. She wondered how the Code could be effectively monitored in those conditions, without losing the benefit of many years of experience. In her view, the Secretariat had not taken full advantage of the national reports submitted. How did it plan to use the data that it had received? What would be done to encourage the exchange of information based on those initial reports? If there was a lack of coordinated and comprehensive data, she suggested that WHO should continue to work closely with OECD to monitor trends in workforce migration. She reiterated the hope expressed by her delegation at the Board's 132nd session and at the recent meeting of its Programme, Budget and Administration Committee that work on the WHO Global Code of Practice would be adequately reflected in the Programme budget 2014–2015.

Mr COTTERELL (Australia) said that his country was working hard towards self-sufficiency of its health workforce and had invested more than 1.5 billion Australian dollars in health workforce reform, increasing training places for physicians, nurses and allied health professions. He urged the Secretariat to continue to work closely with OECD on data collection and workforce planning. OECD had considerable experience in monitoring workforce shortages and migration, and was also examining the impact of the global financial crisis on the health workforce. Many health workforce challenges were closely linked to those of universal health coverage, strengthening of health systems and whole-of-government approaches to health priorities, and Australia therefore encouraged the Secretariat to continue to work in those three areas.

Mr KLEIMAN (Brazil) said that health workforce shortages and migration were common across the world and required a coordinated response from international organizations, Member States, and stakeholders from different sectors that took into account the specific characteristics of each setting. Despite establishing a government department to formulate policies and taking various initiatives to increase the number of medical schools and improve the distribution of health personnel, Brazil was struggling to cope with shortages of health professionals in rural areas. Perhaps the action plan being developed by WHO and the European Union could be shared with countries outside Europe, to help them improve their ability to tackle common problems? He invited all Member States to discuss the matter further at the Third Global Forum on Human Resources for Health, to be held in Brazil in November 2013.

Dr SINGH (India) said that the availability of human resources remained a key constraint to the expansion of health service delivery: merely building infrastructure would serve no purpose unless more health care workers were available. There was a need to increase the number of nursing and medical schools, and to ensure that they were distributed in a geographically more equitable way. India was therefore striving to expand training in areas that were currently underserved and also the training of paramedical and community-level health workers. More attention should be paid to the collection of data on the current health workforce, especially outside the public sector. A national human resources observatory would address such a need. In addition, given the increasing burden of noncommunicable diseases, ageing populations and the high costs of health care, prevention and promotion must be balanced with curative services. Nurses and midwives could play a cost-effective role in boosting health promotion, disease prevention and self-care. India was committed to promoting the deployment of community nurses and midwives in both urban and rural areas, as a means of increasing access to health care and contributing to universal health coverage.

Ms Chun-Ying HUANG (Chinese Taipei) said that to avoid imbalances in the supply and demand of health professionals, Chinese Taipei's training and employment strategy involved conducting regular surveys to measure supply and demand, and subsequently adjusting health workforce development as required. As the critical care sector and remote areas currently faced a shortage of health professionals and severe work overload, steps were being taken to improve working conditions and to provide incentives to health professionals in those areas. Chinese Taipei hoped to establish long-term cooperative exchanges in the area of human resources for health.

Mr BESANÇON (International Pharmaceutical Federation), speaking at the invitation of the CHAIRMAN, welcomed the progress achieved in the reporting of health workforce shortages and migration, although its own surveys had shown that there was little documentation on the migration of pharmacists. The growing number of essential medicines and increased evidence of a lack of responsible use underlined the need for comprehensive planning and for education and training of pharmacists and their support workforce. His organization had welcomed the opportunity to work with WHO on the global survey on human resources for the pharmaceutical sector and was committed to hosting a global pharmacy observatory, to ensure that national and regional data on pharmaceutical human resources were continually updated and made available at the global level. In addition, it would soon be publishing its first global technical report on pharmacy education, prepared in collaboration with WHO, with data analysis covering more than 100 countries, and a qualitative analysis of the drivers affecting pharmacy education in 12 countries.

Ms DE PONTE (Medicus Mundi International – International Organisation for Cooperation in Health Care), speaking at the invitation of the CHAIRMAN, observed that Member States were responsible for implementing the Code and requested to report on progress, and WHO was mandated to ensure the collection of comparable and reliable data for monitoring and analysis. However, the country information gathered through the national reporting instrument was not accessible to organizations such as hers. Transparency of the contents of national reports was an essential requirement for increasing Member States' accountability and the involvement of civil society.

She expressed concern at the lack of sufficient dedicated capacities and financial resources within the WHO Secretariat and at the fact that regional offices sometimes had insufficient resources to liaise with Member States. Such shortages could adversely affect monitoring and reporting on implementation of the Code and on Member States' involvement in the process.

Implementation of the Code and of the necessary monitoring demanded commitment, leadership and a spirit of ownership of the Code at all levels. That spirit needed to be further developed, as the Code was one of the few regulatory instruments adopted by WHO, and its implementation would be seen as a case study of the ability of the Secretariat and its Member States to set global standards and regulations. The technical issue of implementation of the Code was therefore linked to the broader issue of WHO reform and the Organization's overall role in global health governance.

Ms ECCLES (International Pharmaceutical Students' Federation), speaking at the invitation of the CHAIRMAN, welcomed the work done under resolution WHA64.6 to strengthen the health workforce and emphasized the need to include pharmacists as unique practitioners. Health care was increasingly focused on universal health coverage, and the theoretical and practical role of the pharmacist was changing accordingly, as observed in the 2012 Student Declaration on the Future of Pharmacists. There were many areas referred to by the Director-General in her opening address where tasks could be safely and effectively shifted to pharmacists. Additionally, giving priority to payment for pharmacy services rather than for the cost of drug products dispensed had been shown to save costs and incentivize workers by allowing them to perform additional roles. Pharmacists were among the most accessible of health care providers, and much greater use could therefore be made of their skills. She therefore called on Member States and their partners to promote opportunities and incentives for pharmacist-provided services when engaging in workforce planning, and to ensure that the professional education of pharmacy students was geared towards the future. Pharmacy students had

the strong sense of shared purpose referred to by the Director-General and were prepared to contribute to the skills mix required for optimum patient care.

Dr GUINTO (International Federation of Medical Students' Associations), speaking at the invitation of the CHAIRMAN, warned that the health workforce crisis, one of the main barriers to achieving universal health coverage, was in danger of becoming neglected, and should be included in United Nations discussions on health in the post-2015 development agenda.

Although data collection was difficult, accurate information on the nature and scale of migration, and its impact on health personnel planning, was crucial. Member States should develop robust monitoring systems, with the WHO Secretariat taking the lead and providing guidance. Human resources for health planning was essential in order to maintain quality while increasing quantity. Training health professionals required time, commitment, support and investment. Data-driven planning should inform national policies, in accordance with the WHO Global Code of Practice. The Global Health Workforce Alliance, a collaborative effort between different stakeholders, was currently underused and underfunded. Likewise, there was insufficient engagement of health profession students in making the national and global policy decisions on the health workforce that would govern their working lives. He called for a standardized reporting instrument and a framework to ensure timely reporting, identify gaps and inform policy responses; greater involvement of the Global Health Workforce Alliance in the coordination of national health workforce policy development and implementation; active engagement of health profession students; and, most importantly, long-term and comprehensive human resources for health planning by all Member States.

Dr KIENY (Assistant Director-General), thanking speakers for their contributions, acknowledged that although some progress had been made with implementing the WHO Global Code of Practice over the previous three years, greater efforts were needed. The Secretariat would continue to work with Member States and other partners to enhance support for and monitoring of implementation of the Code, to promote the establishment of designated national authorities and to improve country reporting. The Secretariat recognized the role of civil society in supporting the implementation of the Code; State and non-State actors should step up collaboration to reinforce the Code's relevance. The Secretariat had increased its collaboration with OECD to improve data collection in over 60 countries; the necessary strengthening of information systems on human resources for health would remain a priority for WHO's support to countries. It was also increasing collaboration with the Global Health Workforce Alliance to strengthen all relevant activities. The Secretariat had taken note of the request for a review of the current data collection instrument, with a view to collecting more detailed information on health workforce migration trends, and for the sharing of country reports.

**The Committee noted the report.**

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

Dr MOHAMED (Maldives, representative of the Executive Board) said that, at its 132nd session, the Board had considered a report by the Secretariat that outlined progress on eHealth, the need for eHealth standardization and interoperability at all levels of the health system, and matters related to health Internet domain names. The Board had also commented on a draft decision on health Internet domain names submitted on behalf of the European Union and its member states. The Board had requested the Director-General to continue working with relevant bodies to protect the names of intergovernmental organizations and to emphasize that the allocation and use of Internet domain names should not compromise public health objectives. The Board had considered two draft resolutions, one on eHealth, the other on health Internet domain names, and had decided to combine

them into a single resolution, EB132.R8, which contained a draft resolution for consideration by the Health Assembly.

Professor AZAD (Bangladesh), speaking on behalf of the Member States of the South-East Asia Region, said that the establishment of a good health information system in the Region, with adherence to standardization and interoperability, would benefit many people and generate evidence that the rest of the world could learn from. The Region had already adopted a 10-point regional strategy on strengthening health information systems. Some countries had forged ahead with their plans for eHealth: for example, his own country had been recognized with an award by the United Nations in 2011 for digital health. To ensure their interoperability and durability, standards were needed on various aspects of emerging eHealth services.

He welcomed the National eHealth Strategy Toolkit, developed by ITU and WHO to promote standardization and interoperability, and hoped that such support would be continued and extended. The draft resolution contained in resolution EB132.R8 should be adopted as soon as possible, so that countries could design eHealth systems without wasting resources through duplication, faulty design and a lack of interoperability. However, eHealth and health Internet domain names were two completely separate matters and therefore warranted consideration in two separate resolutions.

Dr DIALLO (Mauritania), speaking on behalf of the Member States of the African Region, said that the agenda item under consideration was of particular significance to the African Region, the Internet playing a crucial role in health security, education and training of health personnel, research, and health networks. National health bodies should harness the full potential of health-related information and communication technologies, for exchanging accurate and up-to-date data in line with the International Health Regulations (2005). All African countries had implemented strategies that made use of innovative technologies for public health purposes, but even though the digital divide had been included in the Millennium Development Goals, African countries lacked the legal framework to develop national eHealth programmes and were beset by various other problems. The lack of an international legal framework hindered efforts to respond effectively to fraud, identity theft and the illegal promotion or sale of medicines. As standardization and interoperability of eHealth were other important factors for the development of eHealth across the world, the African Region expressed its support for the adoption of the draft resolution. Every effort should be made to develop, disseminate and implement interoperability standards with support from the Secretariat and Member States, although African countries would require regular funding, especially to procure and maintain the relevant equipment. It was unacceptable for management of the “.*health*” Internet domain to be entrusted to private entities; WHO should manage health-related domain names and work closely with the African Union and the Internet Corporation for Assigned Names and Numbers (ICANN) to draw up appropriate policies to protect the names and acronyms of intergovernmental organizations on the Internet.

Ms CHEDEVILLE-MURRAY (France) hoped that the follow-up measures to the draft resolution referred to by the delegate of Mauritania would keep Member States informed of the latest developments in the area of health-related Internet domain names and protection of the WHO name and acronym. Care should be taken to ensure that the resolution could still be fully applied within the new Internet “architecture” that was being introduced. Her delegation would be prepared to discuss the delegate of Bangladesh’s proposal to split the resolution in two.

Mr SHI Guang (China) commended WHO on its promotion of eHealth as a cost-effective technological solution and the use of data standardization to improve the health outcomes of patients. Information and communication technologies had advanced so rapidly that many developing countries, including China, were struggling to keep their systems updated. Re-engineering of existing health information systems that were out-of-date was expensive and required considerable human resources. For that reason, China appreciated the words “as appropriate” in paragraph 1 of the draft

resolution, which implied that each country should evaluate the cost-effectiveness of health data standardization in its own specific circumstances.

The Secretariat should continue to collaborate with ICANN to ensure that public health interests were protected during the approval of new domain names. Given its technical, staff and management constraints, WHO should look to cooperate with other non-profit organizations to apply jointly for the “.health” domain name. At the same time, China supported WHO in its cooperation with ICANN and other organizations to ensure that the name and acronym of WHO were fully and permanently protected against inappropriate registration by third parties.

**Dr Singh took the Chair.**

Dr TSECHKOVSKY (Russian Federation) drew the Committee’s attention to the importance of cooperating on national eHealth strategies under the aegis of WHO, as otherwise Member States might apply general measures without considering interoperability. He appreciated the Secretariat’s work on Internet domain names and recommended that Cyrillic domain names should also be offered. The Russian delegation endorsed the draft resolution in its current form.

Mr VEGA MOLINA (Spain) said that his country was unwavering in its support for eHealth, as shown by its participation in the European eHealth project, epSOS. Although it was encouraging that WHO was setting eHealth as a priority and that the standards were sufficient to establish the technical infrastructure of eHealth, clinical health professionals must be more aware of them in order to apply them. He urged WHO to lead the way in guiding Member States to apply the standards correctly.

Reducing health inequalities was an ongoing task that entailed, among other things, increasing access to eHealth services. Countries and regions should be able to tailor eHealth to their prevention needs, and public and private incentives should be offered to guarantee interoperability. It would be beneficial to expand electronic databases containing patient records to create health registers that would be more reliable and easier to manage. Standardization was the key to making the information useful for teleconsultation between professionals in remote regions, and for research and assessment of public health. Similarly, scientific studies should be promoted on the efficiency, effectiveness, usefulness, benefits and cost–effectiveness of new technological solutions appearing on the market.

**Mrs Tyson resumed the Chair.**

Dr RANJAN (India) supported the draft resolution. The promotion of information and communication technologies would help to strengthen health systems. He welcomed the WHO/ITU National eHealth Strategy Toolkit and the development by WHO of a handbook on health data standardization and interoperability. The Secretariat should support Member States in integrating the application of health data standards and interoperability in their national eHealth strategies.

Ms JAMEEL (Maldives) supported the draft resolution and expressed appreciation for the WHO/ITU National eHealth Strategy Toolkit and the leadership role of WHO in the promotion and development of eHealth. In 2012, Maldives had approved its national eHealth strategy and was starting to apply the latest technologies in health care delivery, as shown by the introduction of telemedicine kiosks on 39 of the country’s islands. A new integrated health information system was being developed with real-time data on health indicators to enable stakeholders and policy-makers to take evidence-based health care decisions and strengthen monitoring and surveillance. The online system would also include electronic patient records and permit patient access to information, which was particularly important for ensuring continuity of care in a geographically fragmented country like Maldives. It was difficult to guarantee specialized health services to the entire population in her country, so she urged WHO to continue its support for the development of eHealth systems and, in particular, telemedicine.



Ms ROOVÄLI (Estonia) said that eHealth was one of the cornerstones of an open society and that Estonia aimed to promote equal and transparent online access to all public services. In that spirit, Estonia had recently hosted regional consultations as part of the WHO efforts to develop the comprehensive handbook on eHealth standardization and interoperability. In 2012, a European Union health taskforce chaired by the President of Estonia had made a number of recommendations to the European Commission, including the following: to establish a legal framework for managing large quantities of health-related data and thus enhance integration of official and user-generated data; to support health literacy by ensuring that health data were available in a form that patients could easily understand; and to ensure that eHealth applications earned users' trust, since only then would users provide information for feedback on preventive care and for benchmarking and monitoring the performance of health systems. The foundation of each of those recommendations was standardization and interoperability of information. She therefore commended WHO's leadership in the area of eHealth and supported the draft resolution.

Mr PRIMADI (Indonesia) said that standardization and interoperability of health data strengthened health systems and were particularly important for collaboration between administrative levels and in the event of public health emergencies. Later in 2013, Indonesia would host a national workshop to incorporate standards into the national comprehensive health data dictionary. Indonesia stood ready to cooperate with the international community to provide training and technical assistance at the subnational level, particularly given that the country's local government offices had been given authority to develop area-specific strategies. eHealth was included in the country's national health strategic plan 2010–2014, and full implementation of eHealth services, including telemedicine and teleradiology, was considered essential, especially in the challenging remote provinces. He supported the draft resolution in its current form.

Ms BUHAT (Philippines) said that national authorities should address the emerging role of information and communication technologies in the delivery of health services and be aware of their benefits. Her country therefore strongly supported the draft resolution and was committed to developing its own national eHealth strategy, with the support of WHO and other international partners.

Ms BLACKWOOD (United States of America), expressing support for the draft resolution, said that health information technology could help to improve efficiency within the health care system and expand access to high-quality and affordable services for all. She welcomed efforts by regions and Member States to integrate eHealth into national programmes but noted that patients' privacy and interests must be central to all such strategies.

She agreed that the Internet domain names of intergovernmental organizations like WHO needed to be protected from third-party registration through the ICANN process. She therefore encouraged WHO to participate further in meetings of the ICANN Governmental Advisory Committee, which was the appropriate platform for the discussion of domain names by governments and intergovernmental organizations. At its most recent meeting in April 2013, the Committee had issued general advice on safeguards in a number of areas, including consumer protection.

Mr ABDALLAH QASEM (Jordan) suggested that with an increasing number of people looking online for health advice, global governance and internationally agreed criteria on the registration of health-related Internet domain names could inspire trust among users, prevent the further expansion of illicit markets for medicines, medical devices and inappropriate health products, and ensure that the online health environment was transparent, lawful and of high quality. WHO should continue working with appropriate entities such as ICANN, its advisory committees and United Nations organizations to protect the *“.health”* domain name.

Ms BELL (Canada) said that her country had participated in the surveys of the WHO Global Observatory for eHealth and the WHO compendiums on innovative health technologies and eHealth solutions, and it intended to continue contributing to such valuable initiatives in the future. It was important to understand the impact of investment in information and communication technologies on health care systems and health outcomes. Sharing best practices internationally would certainly strengthen the evidence base for eHealth.

With regard to Internet naming conventions, a balance should be found between harnessing the potential of the Internet and protecting users; even before the current process of allocating top-level names had been launched, concerns had been expressed that the initiative might open opportunities for fraud and that the Internet might be beyond the scope of national jurisdictions. Although it was too early to know to the extent to which ICANN would impose measures to protect the public, Canada agreed that WHO should have an influence on the governance of the “.health” domain name if it was allocated to one of the four applicants.

Dr SWANN (Bahamas) said that his country was taking steps to implement PAHO Directing Council resolution CD51.R5 on strategy and plan of action on eHealth. Over the previous 15 years the Bahamas had invested in the creation of an effective data network infrastructure, and 26 island groups would be on the network by the end of 2013. In the Caribbean region, it was a challenge to find suitable information and communication technologies for data collection and universal access to health care. Although private software packages met Health Level Seven International standards, they did not meet all regional health needs or facilitate interoperability. He therefore applauded the development of a WHO handbook on health data standardization and interoperability.

An integral component of the Bahamas’ continuing education strategy for health care workers was eLearning, which had good potential for disseminating education and training materials and would be further bolstered once the data network for the public health sector had been completed.

He looked forward to the outcome of the work that WHO was pursuing with regard to health-related Internet domain names and protection of the names and acronyms of intergovernmental organizations and therefore supported the draft resolution.

Ms HARB (Lebanon) said that her Ministry of Health had established a national eHealth programme and had recently launched a mobile application with the aim of improving both access to health services and transparency. A mobile births and deaths reporting system and a mobile disease notification system were also planned in an effort to enhance vital statistics and disease surveillance, and an eLearning tool would be introduced to train physicians to record causes of death properly and to select appropriate ICD-10 codes. Given the importance of eHealth she called on WHO to continue to support her country in developing its health information system and to continue activities in the application of eHealth. She supported the draft resolution.

Ms CHEDEVILLE-MURRAY (France) proposed that the draft resolution should be amended by adding a paragraph after paragraph 2 along the following lines: “to continue working with the appropriate entities, including the Internet Corporation for Assigned Names and Numbers and its stakeholders, to ensure that decisions by those responsible for health-related Internet domain names take account of public health objectives and protect the name and acronym of WHO”.

Dr DIALLO (Mauritania) said that, although he had no objections to the wording proposed by the delegate of France, it was important to make sure that the resolution formed a coherent whole. Was it wise to make additions to a text that had already been approved by the Executive Board? Speaking on behalf of the Member States of the African Region, he said that he would need to consult further on the matter with other Member States of the African Region.

Ms BLACKWOOD (United States of America) said that her delegation was also open to the delegate of France's proposal. However, at such a late stage of the Health Assembly it might be better to work within the context of the draft resolution proposed by the Board.

Mr Chin-Shui SHIH (Chinese Taipei) said that Chinese Taipei welcomed the draft resolution. Its universal health insurance programme demonstrated the progress it had already made in developing its eHealth system. Chinese Taipei fully understood the importance of using health information to strengthen the overall health care system, enhance health care quality, increase administrative efficiency and prevent insurance fraud. Chinese Taipei stood ready to share its experience in developing eHealth services.

Mrs BERGER (Medicus Mundi International – International Organisation for Cooperation in Health Care), speaking at the invitation of the CHAIRMAN, said that the Internet was an essential tool through which to access health information, and in countries with limited resources, it was sometimes the only way of accessing such information. Health information online should therefore be evidence-based, quality-controlled and trusted. However, none of the four applicants for the “.health” domain name belonged to the health community: all were commercial entities and intended to sell use of the name on a “first-come, first-served” basis. Awarding the management of the domain name to them would be tantamount to placing private interests ahead of the public interest. Supporting the objections against the “.health” applications by the ICANN At-Large Advisory Committee and the ICANN Independent Objector, she questioned whether the general safeguards proposed by the ICANN Governmental Advisory Committee would be properly enforced. Unless strong public health criteria could be applied, people's health would be placed at risk, especially in developing countries.

WHO's Member States and the public health community still had limited awareness of the potential harm of the ICANN process. It was urgent for them to understand the need to set up appropriate mechanisms to govern “.health” in the public interest, and to call for the global public health community to be given a central role. Member States and the Secretariat should act immediately in the Governmental Advisory Committee and other relevant forums to postpone the attribution of “.health”, until the domain could be run in the interest of global public health.

Dr KIENY (Assistant Director-General) thanked Member States' delegates and civil society representatives for their contributions. She assured them that the Secretariat would address their concerns, especially in relation to health data standardization and interoperability, health Internet domain names, and the protection of the WHO name and acronym.

(For continuation of the discussion and approval of the draft resolution, see the summary record of the sixth meeting, section 2.)

**The meeting rose at 17:40.**

## **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.<sup>1</sup>**

### **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.<sup>2</sup>**

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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<sup>1</sup> See page 312.

<sup>2</sup> 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 disproportionately 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.<sup>1</sup> 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

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<sup>1</sup> 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.<sup>1</sup>**

**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;<sup>2</sup>

**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 Guidelines;<sup>3</sup>

**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;

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<sup>1</sup> Transmitted to the Health Assembly in the Committee's fourth report and adopted as decision WHA66(12).

<sup>2</sup> The world health report 2006: working together for health. Geneva: World Health Organization; 2006.

<sup>3</sup> 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 policies~~ and plans 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:<sup>[1]</sup>

- (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** conducting 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;

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

(3) to **consider** formulating and implementing 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-professionals, 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.~~





**(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.<sup>1</sup>**

**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;<sup>2</sup>

<sup>1</sup> Transmitted to the Health Assembly in the Committee's fourth report and adopted as resolution WHA66.23.

<sup>2</sup> 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:<sup>1</sup>

- (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;

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<sup>1</sup> 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]**
- (68) 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.<sup>1</sup>**

**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.

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<sup>1</sup> 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 preparedness, 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.**

## **SEVENTH MEETING**

**Monday, 27 May 2013, at 14:30**

**Chairman:** Mrs K. TYSON (United Kingdom of Great Britain and Northern Ireland)

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

### **Preparedness, surveillance and response**

- D. Strengthening national health emergency and disaster management capacities and the resilience of health systems (resolution WHA64.10)**

Mr DEMIRALP (Turkey) commended the work that had been carried out under the WHO Emergency Response Framework over the previous 12 months. Through its work as the lead agency of the Health Cluster of the Inter-Agency Standing Committee and, with the cooperation of Member States, WHO would be strengthening its capacity and building on its experience within the Framework. Turkey endorsed the Organization's non-political approach to humanitarian and health situations arising from large-scale human rights violations, and encouraged it to continue to limit its scope to ensuring the conditions for a healthy life.

The situation in the Syrian Arab Republic had been categorized by the United Nations as a Level 3 emergency and merited special attention. The WHO report on health conditions in the country (document A66/27 Add.1) was particularly important as it was the first presented to the Health Assembly since the start of the crisis. The Secretariat should prepare regular progress reports, in which the unique nature of the Syrian conflict should be acknowledged, in order to draw the international community's attention to the country's deteriorating humanitarian situation and to provide objective information, including WHO's response to the challenge of humanitarian access and its geographical coverage of the country; the specific needs of the country's populations; and WHO's relations with the Syrian opposition, in particular its cooperation with the Assistance Coordination Unit of the Syrian National Coalition for Syrian Revolutionary and Opposition Forces.

Mr BOUGACHA (Tunisia) commended the efforts made by WHO, its field structures and its partners, as well as by neighbouring countries and United Nations organizations, to deliver a wide range of health care services to Syrians, both inside and outside the Syrian Arab Republic, and to cope with the significant shortage of medical teams and supplies. WHO had played a pioneering role as the Health Cluster lead agency, and he urged it to intensify its efforts. He also requested Member States to refrain from politicizing WHO's involvement in the Syrian crisis to avoid hindering the delivery of assistance or endangering those working in the field.

The Organization's interventions in Mali were satisfactory and its support for the health sector, including the supply of medicines, should continue on the basis of needs estimates. As to the situation in the Central African Republic, WHO was playing a valuable role in coordinating collaboration with the Ministry of Health in order to restore the disease surveillance system, establish a rapid response mechanism and resume immunization services. Such health care efforts must be pursued.

Ms LANTERI (Monaco) thanked WHO and its staff for their work in what were sometimes extremely hazardous circumstances. It would be particularly appropriate, in the context of WHO reform and the implementation of the Emergency Response Framework, for the Secretariat to report to

the Executive Board and the Health Assembly on the humanitarian operations being conducted by WHO under its mandate as Health Cluster lead agency. In response to the conflict in Mali, her country was providing food aid to more than 1000 displaced families and carrying out various health projects, while remaining attuned to changes in the situation and in people's needs. With regard to the Syrian Arab Republic, Monaco was profoundly concerned about the deterioration in sanitary conditions and access to water. It vigorously condemned the deliberate and repeated attacks on medical personnel; medical and humanitarian personnel must have full, immediate and unrestricted access to people, in complete security and without any discrimination, in order to meet health needs. The efforts made by the authorities and populations of neighbouring countries to host refugees and meet their needs were commendable.

Dr AL-THANI (Qatar) commended WHO's multi-pronged approach to providing Syrian citizens greater access to health services and its efforts to develop an essential medicines list in order to alleviate the acute shortage of medicines and supplies in the interior of the country. The health infrastructure in the Syrian Arab Republic had collapsed, yet the Government continued to block access to various locations that were in need of medical assistance.

He condemned the embargo imposed on Qusair and the killings of civilians, including women and children, by the Government, which must be reminded of its obligations under international humanitarian law, and of the need to ensure that health workers had access to the injured. The health services provided by WHO and other humanitarian organizations were inadequate in the face of growing needs and the restrictions imposed on humanitarian workers generally. Cooperation with the Assistance Coordination Unit of the National Coalition for Syrian Revolutionary and Opposition Forces was thus essential to ensuring service delivery to the largest possible number.

The high numbers of Syrian refugees in neighbouring countries had led to the disintegration of health facilities. WHO and other humanitarian organizations were therefore urged to increase support to enable those countries to meet vital health needs. Qatar was fully committed to standing by the Syrian people, and had launched a fourth phase of humanitarian assistance; funding of US\$ 25 million would be provided for the inhabitants of Syrian refugee camps in Lebanon, where it had also established a public health centre for treating emergency patients.

Ms GOLBERG (Canada) said that the Emergency Response Framework, which had been applied to a large number of humanitarian crises over the previous 12 months, had proved to be an important means of identifying and prioritizing health interventions to save lives when emergencies arose, and she endorsed the Organization's plan to strengthen it further. By improving coordination, supporting enhanced United Nations leadership and strengthening accountability to those in need, WHO would ensure that its emergency interventions were more efficient and effective. With respect to the situation in the Syrian Arab Republic, she commended WHO's efforts to ensure access to medical services under difficult circumstances, and urged all parties to the conflict to respect international humanitarian law. She endorsed the Organization's call for all those concerned to protect the neutrality of health workers, facilities and services, and for health workers to deliver services in an impartial and ethical manner. A key opportunity for coordination and exchange of information between WHO and its partners was provided by the Health Care in Danger project, implemented by the International Committee of the Red Cross in order to determine where violations against health care workers and facilities were taking place.

Mr CORR (Ireland), speaking on behalf of the European Union and its Member States, pointed out that the situations in Mali, the Central African Republic and the Syrian Arab Republic were all complex but differed in nature and scale. The European Union was appalled by the dire humanitarian and health situation in the Syrian Arab Republic and by its impact on neighbouring countries, which had generously taken in so many refugees. In particular, it deemed unacceptable the fact that medical personnel, health facilities and vehicles were being deliberately targeted in acts that might amount to war crimes, the prime responsibility for which lay, as had been established by various United Nations

reports, with the Syrian authorities. He therefore called on all parties to the conflict to respect international humanitarian law, and stressed the urgent need for them, in particular the Government of the Syrian Arab Republic, to remove all obstacles to the delivery of humanitarian assistance. The European Union was committed to remaining a leading donor of such assistance. It fully supported WHO's role as Health Cluster lead agency and urged it to continue monitoring the situation in the Syrian Arab Republic and provide a comprehensive update on it and other such crises to the Sixty-seventh World Health Assembly through progress reports.

In response to the situation in Mali, the European Union called for basic services to be restored, for humanitarian organizations to have unimpeded access to the most vulnerable populations, and for international humanitarian law and human rights to be respected. It was nevertheless encouraged by the positive outcome of the recent high-level donor conference for development in Mali and would make every effort to support humanitarian relief and build resilience. It was equally concerned by the situation in the Central African Republic and called on the transitional authorities and all other parties to work together to restore public services and meet the basic needs of the population, and to respect international humanitarian law.

Professor HALTON (Australia) said that lack of protection for those providing and receiving health care in situations of armed conflict was a global problem. Her own country had therefore become a key partner in the Health Care in Danger project, which aimed to strengthen health care protection in armed conflicts. Australia, deeply concerned at the scale of the crisis in the Syrian Arab Republic, and its impact on health services, was working to ensure, as a priority, access to essential medicines, and full protection and access for medical workers, supplies and facilities. It had contributed nearly 80 million Australian dollars for humanitarian assistance both within and outside the country, nearly one third of which had been allocated to health care support. It had also endorsed the February 2013 Common Statement on Access to Medical Care in Syria, which called on all parties to the conflict to respect the rules of international humanitarian law. The serious and growing refugee crisis in neighbouring countries was putting a strain on their health systems and called for greater international assistance. However, United Nations appeals remained underfunded, and she therefore urged all partners to honour the pledges made at the International Humanitarian Pledging Conference for Syria held in Kuwait in January 2013.

Mr NIEMTCHINOW (France) said that the situations in Mali, the Central African Republic and the Syrian Arab Republic were extremely complex but in no way comparable. The humanitarian crisis in the Syrian Arab Republic was alarming in nature and scope, with the authorities in Damascus flouting the basic principles of international humanitarian law. Their deliberate targeting of physicians, hospitals and health centres constituted war crimes and had been denounced in several United Nations reports. The health system was on the verge of collapse, the epidemiological situation was deteriorating dangerously quickly and people were afraid to attend health facilities. He commended the Organization's efforts to provide health care to the Syrian people, and encouraged it to continue doing so. He also urged it to monitor the situation in the Syrian Arab Republic closely and report thereon to the Sixty-seventh World Health Assembly. The Health Assembly must call upon the Syrian authorities to respect and ensure the security of medical personnel and health care centres.

With regard to the situation in Mali, a recent donor conference for development had mobilized US\$ 3.2 million and pledges had been made to resume the country's development programmes, which should make it possible to restore health services in Mali to an adequate level. Those commitments had sent a message of hope to the entire population. France was particularly alarmed by the health care crisis in the Central African Republic, however, and called on the international community to come to its aid.

Dr TRAORE (Mali), speaking on behalf of the Member States of the African Region, said that, despite being frequently obliged to operate under difficult social and political circumstances, the Region's countries had made progress towards strengthening their capacity to manage health

emergencies and disasters. In 2012, the Regional Committee for Africa had adopted resolution AFR/RC62/6 on disaster risk management: a health sector strategy. Five regional economic communities in Africa had adopted risk prevention policies or strategies based on the priorities set out in the Hyogo Framework for Action 2005–2015. In addition, several countries had established epidemic or disaster funds and emergency health services. However, owing essentially to financial constraints, Africa had not yet fully attained its objectives in that regard.

The Member States of the African Region called on all stakeholders to step up their post-crisis reconstruction efforts in the Central African Republic and Mali and requested them to provide the technical, financial and material support needed to strengthen the resilience of the Region's health systems, a necessary step towards attainment of the Millennium Development Goals.

Ms STIRØ (Norway) commended WHO's response to the health care emergency in the Syrian Arab Republic and encouraged it to pursue its efforts to gain access to all parts of the country and to expand its cross-line operations. The Organization's success in forming partnerships with a network of local nongovernmental organizations at an early stage in the conflict had made it one of the most efficient United Nations organizations in terms of operational outreach, and less dependent on the Syrian Arab Red Crescent, whose capacity was stretched to the limit. That had also enabled it to act promptly in providing cross-line humanitarian assistance in areas that had previously been inaccessible to the United Nations, especially in the north of the country. Her country had been providing WHO with funding earmarked for health sector and sanitation operations in the Syrian Arab Republic, and had recently extended its funding agreement.

Mr MULREAN (United States of America) fully supported the work being done by WHO and other organizations to address health needs in Mali and the Central African Republic and the Syrian Arab Republic.

He expressed profound concern about the health crisis in the Syrian Arab Republic, which had been classified as a Level 3 emergency. Medical facilities and staff were being deliberately targeted, public health was at grave risk, and humanitarian organizations were facing dire conditions or being refused access. Neighbouring countries, which were providing the majority of health services to Syrian refugees, also faced difficult challenges. In the case of Jordan, the majority of Syrian refugees were not in camps and were therefore beyond the reach of the Office of the United Nations High Commissioner for Refugees, thus overburdening the country's health system.

The United States of America was providing humanitarian support both inside the Syrian Arab Republic and in neighbouring countries. With funding from his country, WHO was working to strengthen and expand the Syrian Arab Republic's early warning and response system for epidemic threats. The United States of America was also providing support to the Assistance Coordination Unit of the Syrian National Coalition for Syrian Revolutionary and Opposition Forces with early warning and disease surveillance activities.

In addition to its humanitarian efforts, WHO was actively supporting the United Nations Secretary-General's team investigating the possible use of chemical weapons in the Syrian Arab Republic. The international community had made it clear that all violations of international humanitarian law in the Syrian Arab Republic were unacceptable, and he called on all parties to protect medical personnel, facilities and transport systems, to ensure unimpeded and non-discriminatory access to those in need of assistance, and to respect their obligations to ensure humanitarian access and assistance in the Syrian Arab Republic. Those activities were urgently required and were independent of the political conflict.

Dr AMMAR (Lebanon) said that Lebanon had witnessed a massive influx of displaced persons since the beginning of the Syrian conflict. The first wave of arrivals had been rapidly integrated into Lebanese households, which had generously shared shelter and food, but host family capacity had been exceeded, and several camps had recently been set up, albeit with very poor sanitary and hygiene conditions. Primary health care services were being provided to displaced persons without any

discrimination, overstretching the Lebanese supply system and leading to periodic shortages of vaccines and medicines. The early warning system had been strengthened to deal with the threat of epidemics, and national immunization campaigns had been conducted throughout the country. However, communicable diseases were on the rise and there was an urgent need to improve water quality and sanitary conditions. Lebanon urged the Organization to play a more active role in fundraising and assistance on the ground. The WHO country office in Lebanon should be given the support it needed to lead the Lebanon Crisis Health Cluster in conjunction with the country's Ministry of Health.

Mr USTINOV (Russian Federation) said that the Secretariat's response to the grave situation in the Syrian Arab Republic was appropriate and timely; the use of a multi-pronged approach had enabled it to improve access to health services and essential medicines for the affected population. His country condemned any politicization of the debate on strengthening national health emergency and disaster management capacities, and refused to be drawn into the present political discussion, despite disagreeing with the viewpoints of several countries. Humanitarian assistance must be governed by the principles of neutrality, impartiality, humanity and independence, as well as respect for territorial integrity and sovereignty, as set out in the Charter of the United Nations and the relevant United Nations resolutions.

Dr AFZAL (Pakistan) said that her country's vulnerability to natural and man-made disasters had prompted it to draw up a national disaster risk management framework and a national disaster risk reduction policy. The national health emergency and response network was active in various fields including coordination and liaison, capacity-building, training, identifying gaps in the health system, ensuring that medicines and medical supplies were available, and developing national guidelines for disaster prevention and surveillance. Pakistan looked forward to additional cooperation with WHO and other international partners in seeking to manage and reduce disaster risk.

Ms PENEVEYRE (Switzerland) said that her country was concerned by the catastrophic impact of deteriorating health systems on people affected by emergency and disaster situations. It was also profoundly concerned about attacks targeting health personnel, facilities and services, and underscored the obligation of all parties to a conflict to comply with the rules of international humanitarian law. She commended WHO's efforts to provide support to the populations concerned, in very difficult circumstances, and deplored the difficulties it encountered in the discharge of its functions.

Dr NICKNAM (Islamic Republic of Iran) said that he was confident that the Health Assembly, in considering the matter of strengthening national health emergency and disaster management capacities, would respect the Organization's Constitution and long-standing practice, and would not allow its prevailing professionalism to be overshadowed by matters that might jeopardize its integrity and efficiency. The Secretariat's efforts to help people on the ground and to attain the principal emergency response goals required support. WHO needed an enabling environment to discharge its functions, and all constraints, including insufficient core financing and rapid response funds, should be eliminated without delay.

Disruption of the health systems in Mali, the Central African Republic and the Syrian Arab Republic was a matter of serious concern, the consequences of which could have long-term adverse effects on population health. There was no excuse for attacks on health workers, facilities and services; such attacks must be categorically condemned by the international community and stopped immediately. Health staff, facilities and equipment, and health care recipients should be protected at all times.

He endorsed WHO's decision to strengthen further, in collaboration with the national governments concerned, its capacity to furnish a rapid response to the needs of emergency-affected populations. Governments must avoid taking any action that violated the independence, sovereignty



and territorial integrity of the countries concerned. The international community should strive to create the conditions under which the populations in those countries could act on their own.

Dr SUKAYRI (Jordan) said that his country's health budget was under immense pressure owing to its efforts to fulfil its obligations to deliver health services to the many refugees from the neighbouring Syrian Arab Republic, in addition to its own citizens. While thanking WHO and other international humanitarian organizations providing health and other services to those refugees, he drew the attention of Member States and donors in particular to the fact that those services were virtually confined to refugees living in camps, who accounted for less than one third of Syrian refugees in Jordan. The Ministry of Health of Jordan was providing services, including the immunization of children under five years of age, to many more refugees outside the camps. Cases of infectious diseases long ago eradicated in Jordan had also emerged and the fear was that further diseases would appear during the summer owing to environmental degradation and water shortages. Citing the principle of burden-sharing, he appealed to donors to provide material and other support to enable the Jordanian Ministry of Health to continue its delivery of health services to Syrian refugees.

Dr WARIDA (Egypt) expressed deep concern over the catastrophic health situation resulting from the Syrian crisis, which had caused many thousands of deaths and injuries and disrupted the country's health system. Egypt was doing its best to provide integrated health services to the Syrian refugees it was hosting. It supported WHO's efforts to deliver health and medical services to the Syrian people, including the war-injured, mothers and children, and those with psychological problems. He called for an end to the attacks on health workers and facilities: their neutrality must be respected and health service delivery must be carried out in an unbiased and ethical manner, in accordance with international humanitarian law.

Ms ISSA (Syrian Arab Republic) said that the apparent attempts to politicize the Syrian situation and divert focus away from its humanitarian dimension were highly regrettable. Her delegation fully rejected the delegation of Turkey's call for WHO to work with a political entity such as the National Coalition's so-called Assistance Coordination Unit, as such action would constitute a violation of the guiding principles for the provision of humanitarian assistance, annexed to United Nations General Assembly resolution 46/182, pursuant to which the affected State had the primary role in overseeing humanitarian operations within its territory. Furthermore, a large quantity of medicines looted from Aleppo had been smuggled into Turkey in flagrant violation of international humanitarian law.

Her delegation likewise rejected all accusations contained in the statements made by the delegates of France, Qatar and the United States of America. Those Member States were directly involved in supporting, financing and training armed terrorist groups, which were thus encouraged to target Syrian hospitals, health centres and pharmaceutical facilities. Atrocious as that situation was, it did not prevent the Government of the Syrian Arab Republic from delivering full health care services, including medicines, to citizens in all regions, without discrimination and free of charge.

Living conditions for Syrian citizens had undeniably deteriorated as a result of the unilateral economic sanctions imposed primarily by the European Union, the United States of America, France, Qatar and Turkey while simultaneously claiming concern for those citizens and their essential needs and denying that they were the target. Those immoral sanctions had had an adverse impact on efforts to meet citizens' needs, in particular medical needs; moreover, relief operations had been so badly affected as to prompt the Government to authorize United Nations organizations to import the oil needed to carry them out.

Certain countries, and member states of the European Union in particular, should bear in mind that, pursuant to United Nations General Assembly resolution 46/182, in providing humanitarian assistance, the sovereignty, territorial integrity and national unity of States must be fully respected. The Government of the Syrian Arab Republic rejected the direct and indirect transfer of assistance across borders on humanitarian pretexts as a violation of that provision. It was cooperating fully with

the United Nations and its humanitarian agencies, offering every facility for the delivery of assistance to all areas, without discrimination, as evidenced by its committed actions on that score. At the same time, however, it refused to countenance any attempted violation of its sovereignty and borders on humanitarian pretexts; nor would it permit any exploitation of the humanitarian suffering of its people by countries seeking to further political agendas through interference in Syrian internal affairs.

The Government of the Syrian Arab Republic would continue to cooperate in providing assistance to its citizens, in compliance with the guiding principles annexed to United Nations General Assembly resolution 46/182.

Mr CARTER (International Federation of Red Cross and Red Crescent Societies), speaking at the invitation of the CHAIRMAN, commended the work of WHO and its partners in strengthening national health emergency and disaster management capacities. However, more efforts should be made to link nutrition interventions with health system strengthening. His organization was committed to strengthening community action and to pursuing its focus on local capacity for disaster preparedness and response; its huge network of volunteers across the globe reached many millions of people affected by disasters every year. Community-based action was vital to ensuring clinical coverage, disease prevention and sustainable behaviour change. Its effectiveness would be enhanced by action to ensure funding for local health systems, consisting of local health workers, strong coordination structures, comprehensive surveillance systems and reliable logistic supply chains. He encouraged Member States to use his organization's substantial community-based resources in tackling malnutrition crises.

Ms Chun-Ying HUANG (Chinese Taipei) said that Chinese Taipei had set up medical assistance teams on the first anniversary of the September 1999 earthquake in order to bolster front-line health care systems facing increased demands for emergency medical care in times of crisis. It had also established six regional emergency operation centres to coordinate emergency response measures; the centres were responsible for dealing with hazards, monitoring, and ensuring immediate access to information on regional catastrophes. Chinese Taipei was eager to share its experience with health authorities in other Member States.

Ms CHAPMAN NYAHO (World Vision International), speaking at the invitation of the CHAIRMAN, said that Member States should give priority to ensuring: that emergency management and disaster preparedness were included in health budgets; that disaster risk reduction was included in health policies and plans at all levels; and that specific health concerns were included in disaster management policies across sectors. In addition, Member States should comply with United Nations guidelines when planning and building health facilities and strengthen local emergency risk management through closer ties with relevant central authorities. Health staff, including community health workers, should be involved in contingency planning and simulation exercises for all hazards, and community participation in policy development and advocacy should be encouraged. Training in disaster management should be provided at all levels. Member States should also establish community safety nets, including insurance; strengthen early warning and information systems; and use environmental and disease surveillance data to prepare for and respond to disasters.

Dr AYLWARD (Assistant Director-General) said that much of the Organization's work in emergency response during the previous year had been based on the new Emergency Response Framework, which was fully aligned with the Inter-Agency Standing Committee agenda and the major thrust of which was to give WHO country offices the capacity to act as quickly as possible in emergency situations. The Framework would be the object of an inter-agency review at the end of its first 12 months of operation.

WHO had been scaling up its operations in Mali rapidly and, at the request of governments, had focused on coordination of the sector response, technical support in specific areas, and information management. However, it had been impeded in those efforts by a lack of funding. A recently

completed assessment on the impact of the crisis on Mali's health facilities was guiding the efforts of the Organization, the country's health ministry and other partners, and was determining the priorities for response and recovery activities.

WHO was focusing its activities in the Central African Republic on early warning systems and vaccination delivery, but again was faced with a shortage of resources. With regard to the 2013 health sector appeal for the Central African Republic, only 13% of the target had been reached to date. An additional constraint was the looting and destruction of the Organization's own facilities in the country.

With regard to the Syrian Arab Republic, the Organization was working both inside the country and in neighbouring countries to meet the needs of the Syrian people, as indicated in document A66/27 Add.1. The WHO country office had rapidly reoriented its focus, and staff with substantial expertise in dealing with emergencies had been brought in.

The Regional Director of the European Region and the Regional Director of the Eastern Mediterranean Region had together spearheaded the effort to establish a new standard framework for enhancing support to refugee populations and host communities in the five neighbouring countries most deeply affected by the crisis in the Syrian Arab Republic. WHO was working closely with UNHCR and health ministries in those five countries. It had also established an emergency support team in Amman and was setting up with UNHCR a regional coordinating committee for the health needs of Syrian refugees.

WHO would be transmitting information on the geographical scope of its operations and on health needs in each area where assistance was being provided through briefings in the Syrian Arab Republic, at the centre in Amman and at headquarters in Geneva. It would continue to press for additional mechanisms to reach all Syrians in need, and was committed to stepping up its support.

In the period 2013–2014 the Secretariat would be working with Member States to develop a disaster and emergency risk management framework that would build more systematically on the International Health Regulations (2005), and would expand capacity-building and preparedness efforts to include all hazards, in conjunction with national disaster management agencies.

WHO continued to urge all parties to protect and respect the neutrality of health workers and services and to encourage health workers to deliver services in an impartial and ethical manner in all crisis areas. He reiterated WHO's commitment to leading the Global Health Cluster, and said that he would endeavour to respond to Member States' call for more frequent reporting on WHO's emergency and disaster management capabilities.

#### **E. Climate change and health (resolution EB124.R5)**

Ms LANTERI (Monaco) commended WHO's efforts in the important area of climate change and health. Monaco had been cooperating for many years, through the Monaco Scientific Centre established in 2006, with WHO's Department of Public Health and Environment. The study of climate change and health was especially significant in the light of the new global action plan for the prevention and control of noncommunicable diseases and the proposed global mechanism to coordinate United Nations system activities in that field.

Ms WANGMO (Bhutan) said that climate change represented a significant and emerging threat to public health and affected the key social determinants of health – air, water, food and shelter. She noted WHO's efforts, in conjunction with other United Nations agencies and partners, to include a health perspective in the climate change framework, and to promote and support the production of scientific evidence. Bhutan was one of the seven countries participating in the global pilot project on health adaptation to climate change and considered the project to be highly relevant.

Mr DEANE (Barbados) said that Barbados was the only country in the Region of the Americas to participate in the global pilot project on health adaptation to climate change. The project would provide the vulnerable Caribbean region with an opportunity to study management and mitigation

strategies. It had drawn the attention of a wide range of stakeholders and had helped to raise the population's awareness of global climate change, primarily through the local press. Data gathered so far suggested that mitigation measures and more extensive monitoring were needed in certain areas. Global climate change would require longitudinal studies, and new questions arising in the course of data collection would also need to be investigated. To that end, he suggested that the Director-General should conduct an assessment of the project and extend its workplan beyond 2014.

Dr HAQUE (Bangladesh) said that Bangladesh was among the countries most affected by extreme weather events. According to the Intergovernmental Panel on Climate Change, the rise in sea levels due to global warming could flood large areas, leaving millions of Bangladeshis as refugees by 2050. Climate change would also exacerbate health inequalities between rich and poor people. Bangladesh had established an adaptation programme to cope with natural disasters and had conducted research aimed at understanding the relationship between diarrhoeal diseases and climate change. It had set up a special unit within the Ministry of Health to coordinate various programmes on risk reduction and increasing adaptive capacity to climate-sensitive diseases. Most countries in the South-East Asia Region, including his own, lacked the scientific expertise and financial resources needed for effective management of climate change programmes, and he urged industrialized nations, which contributed the most to greenhouse gas emissions, to provide greater technical and financial support to countries that experienced their consequences.

Ms PETRAVIČIŪTĖ (Lithuania) commended the Secretariat's work in the field of climate change and health, in collaboration with Member States and other partners. Further efforts were needed, for example, to study the impact of climate change on health and health systems, and the need to build national capacities to measure that impact. In addition, more health topics should be included on the international agenda, including that of the United Nations Framework Convention on Climate Change negotiations. Lithuania had adopted a climate change management strategy for 2013–2020 and an intersectoral action plan, but owing to its lack of capacity and expertise in the field, would need the Organization's support to implement its plans. In that connection, it endorsed the development of a WHO workplan on climate change and health for the period 2014–2019.

Mr TOMLINSON (United Kingdom of Great Britain and Northern Ireland) said that in April 2013 his country had contributed an additional £6.8 million to support WHO's valuable work on climate change and health, one highlight of which was the excellent Atlas of Health and Climate, produced in partnership with WMO. He welcomed WHO's contribution to developing the Global Framework for Climate Services, again in conjunction with WMO, and encouraged it to ensure that health remained on the Global Framework's agenda. He requested the Secretariat to revise the Organization's current workplan on climate change and health, in line with the Twelfth General Programme of Work and the Programme budget 2014–2015 adopted by the current Health Assembly.

Mr IZWARDI (Indonesia) said that his country was facing a rapid and acute impact of climate change on human health owing to its geography, and was making substantial efforts to deal with the situation. It had established a national climate change council and an intersectoral roadmap for climate change, and instituted measures including health vulnerability mapping, drawing up regulations and policy, and collecting evidence-based data. In 2012 the Ministry of Health had set up a team to coordinate intersectoral cooperation under the national strategy for climate change adaptation. Policy- and evidence-based interventions were being introduced in order to raise awareness within the health sector and in communities. Further activities included ensuring that health system capacity and institutional arrangements were adequate to deal with the anticipated disease burden resulting from climate change; expanding disease surveillance systems; and providing support for health research. Technical support from United Nations agencies and development partners as well as sharing of experiences would bolster his country's efforts to cope with climate change.

Mr LI Mingzhu (China), endorsing the development of a WHO workplan on climate change and health for 2014–2019, welcomed WHO's efforts to raise awareness of the impact of climate change on health since that would encourage the international community to pay greater attention to the issue, encourage countries to integrate the climate change and health dimension into their overall strategies for responding to climate change, and in turn strengthen the health sector's capacity to respond to it.

Climate change had increased the frequency of natural disasters worldwide, creating serious health threats and overburdening the delivery capacity of health systems. It was therefore important to strengthen health infrastructures to cope with emergencies more effectively. His Government had taken a multisectoral approach, and was participating in the global pilot project on health adaptation to climate change. Mitigation of climate change was a relatively long-term undertaking while adaptation was a more realistic and immediate approach, better suited to developing countries. WHO should embrace the principle of shared but differentiated responsibilities in its work with such countries.

Ms BURRIS (United States of America), endorsing WHO's workplan on climate change and health, said that it was important for the Secretariat to use the assessments carried out by the Intergovernmental Panel on Climate Change and the United Nations Framework Convention on Climate Change to guide its work in that area. She encouraged WHO to join the Climate and Clean Air Coalition to Reduce Short-lived Climate Pollutants; the Coalition had expressed an interest in working with WHO to help advance understanding of the human health implications of those pollutants. In drawing up its plans for developing the health aspects of national adaptation plans, the Organization should focus on the collection and dissemination of reliable data on which Member States could base their policy decisions, and the provision of technical support for their implementation.

Ms JAMEEL (Maldives) said that her country was actively engaged in climate change efforts. It had played an important role in the negotiations that had led to the United Nations Framework Convention on Climate Change and had been among the first to sign the Kyoto Protocol. Maldives was one of the countries most vulnerable to the predicted effects of climate change, including the risks from sea level rise, decreased food and water security, and increased prevalence of vector-borne diseases. Like other small island states, its country's inadequate sewage and waste management systems favoured the spread of diarrhoea and other water-borne diseases. Most critically, its health systems were funded by tourism, which depended on the environment as its main asset. If Maldives failed to pay adequate attention to the health impacts of climate change, its health and development achievements would be compromised. She urged WHO to step up its support to Member States in respect of both mitigation and adaptation measures, and to continue efforts to collect evidence on the health impacts of climate change.

Dr AFZAL (Pakistan) said that the effects of climate change on health were placing an extra burden on health care systems. Under its national climate change policy, Pakistan was instituting various measures, which included assessing health vulnerabilities, building community capacities, incorporating climate change issues into the national health plan, mobilizing resources, upgrading monitoring and forecasting systems, and conducting research. In drawing up the workplan on climate change and health for the period 2014–2019, the Secretariat should place greater emphasis on the specific topic of strengthening health systems to protect populations from the adverse impacts of climate change on health.

Dr HARTIGAN-GO (Philippines) said that his country's department of health was working with WHO to meet the challenge of climate change, guided in particular by the Regional Framework for Action to Protect Human Health from the Effects of Climate Change in the Asia-Pacific Region. His Government had taken a number of key policy initiatives including the drafting of legislation, development of a national framework, and establishment of a special division and a technical committee on climate change and health. From 2008 to 2012, the Philippines had implemented a

flagship programme on climate change strategies in cooperation with United Nations organizations and government partners.

Dr AL-TAAE (Iraq) said that environmental factors could have significant effects on the prevalence and epidemiology of communicable and noncommunicable diseases. Iraq had included strategies to combat the adverse effects of climate change in its public health and primary health care workplan, with emphasis on vulnerable population groups. It had also shared expertise with Afghanistan, the Islamic Republic of Iran and Pakistan, under the auspices of WHO. Joint activities had focused on climate-change preparedness and responding to the health challenge of mass gatherings. He urged WHO to foster capacity-building within and between regions and to encourage partnerships among stakeholders to deal with the health effects of climate change.

Mr CORRALES (Panama), commended WHO's efforts in the field of climate change and sustainable development. Countries like his own that were the most vulnerable and had the greatest exposure to violent weather events and disasters must use a multisectoral approach to cope with the effects of climate change on human health. Greater attention should be paid to strengthening the health component of adaptation plans. WHO had an important role to play in the negotiations under the United Nations Framework Convention on Climate Change, and he encouraged Member States to participate actively in those negotiations.

Ms MALONE (World Meteorological Organization) said that, as delegates had pointed out, weather, water and climate, especially extreme conditions, clearly affected health, the decisions WHO took in terms of investment in infrastructure and programmes, and programme outcomes. Effective planning for preventive action against climate-related health risks was dependent on a better understanding of the relationship between climate and health and broad cooperation between climate and health services at all levels across the world. Key tools in that regard were the Atlas of Health and Climate and the Global Framework for Climate Services. In 2012, WMO had adopted an implementation plan for the Global Framework for Climate Services, launched in 2009. WMO acknowledged with appreciation the active participation of the Director-General and her staff in that process. Following on from their effective collaboration on the Atlas of Health and Climate, WMO and WHO were establishing a joint change project office on climate and health, which was expected to commence operations later in 2013. In addition, WMO, WHO and the WFP, together with partners in Norway, were developing projects to demonstrate the application of climate services in support of health and nutrition in Africa. Such projects were financed through the Global Framework for Climate Services Trust Fund, thanks to the generosity of donors to the Fund.

Ms Yu-Hsuan LIN (Chinese Taipei) said that health care systems could play an important role in mitigating the effects of climate change. Chinese Taipei had been working with the WHO International Network of Health Promoting Hospitals and Health Services to promote activities consistent with WHO guidance on climate change. Hospitals, which had a high energy consumption, were being encouraged to reduce their carbon footprints and to work with the international coalition Health Care Without Harm in order to promote environmental sustainability in medical institutions; a manual had been produced to assist hospitals in assessing environmental compliance; and healthy lifestyles were being encouraged in order to reduce the use of medical resources. Chinese Taipei would continue to strengthen international cooperation in the field of climate change and health by freely sharing its monitoring tools and methods.

Ms MARIC (CMC – Churches' Action for Health), speaking at the invitation of the CHAIRMAN, said that climate change, one of the most significant challenges to global public health, was best addressed through a rights-based approach that emphasized the need to protect the most vulnerable. In its efforts to draw attention to the health consequences of climate change, the Organization had made valuable contributions at the United Nations Conference on Sustainable

Development (Rio+20) and at the eighteenth session of the Conference of the Parties to the United Nations Framework Convention on Climate Change. However, it should show stronger leadership in promoting action that met the standards required by the best available science, in particular, by spearheading Member States' efforts to obtain adequate public funding for adaptation through the establishment of health-related funding windows in the Green Climate Fund; stepping up its efforts to measure the health-related consequences of climate change; and encouraging Member States to take the most appropriate action to deal with the adverse effects of climate change on health.

Dr FUKUDA (Assistant Director-General) said that climate variability affected all countries, although some, as the delegates of Bangladesh and Maldives had made clear, were particularly vulnerable to the short- and long-term effects of climate change. The delegate of Iraq had rightly pointed out that climate change had a very broad impact on health and affected both communicable and noncommunicable diseases in a variety of ways. He acknowledged with appreciation the financial contribution made by the United Kingdom of Great Britain and Northern Ireland. He thanked WMO for its collaboration, in particular in the development of the Atlas of Health and Climate, and assured the delegate of the United States of America that WHO collaboration with the Climate and Clean Air Coalition to reduce Short-lived Climate Pollutants was already under way. As suggested by the Executive Board, and supported during the current discussion, the current workplan on climate change and health would be extended, and contributions from Member States would be welcome in that regard. He noted that a large number of countries were developing national plans using intersectoral approaches to tackle the effects of climate change on health, which were crucial to work in that area.

**Health systems** (continued from the sixth meeting, section 3)

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

Mr FEDOTOV (International Labour Organization) said that ILO and WHO had cooperated for the previous five years on implementation of the global plan of action on workers' health, which had included the establishment of national programmes for the elimination of silica- and asbestos-related diseases, development of the ILO List of Occupational Diseases, integration of essential interventions for workers' health in primary health care, development of healthy workplace programmes, and formulation of national occupational safety and health policies, programmes and services. Although joint action at national level by ministries of health and labour had given rise to significant gains for workers' health, too many countries still lacked policy and services for protecting the health of their workers, and more than 2 million people died of occupational diseases every year. WHO's efforts to link occupational health services to universal health coverage and to integrate occupational health activities into global action on prevention of noncommunicable diseases were therefore welcome. ILO was strongly committed to continuing its fruitful collaboration with WHO on occupational health.

Mr CARTER (International Federation of Red Cross and Red Crescent Societies), speaking at the invitation of the CHAIRMAN, said that limited access to water and poor sanitation contributed to more than 3 million deaths each year and was one of the leading causes of child mortality. Water and sanitation were a basic human right that, when denied, brought shame and stigmatization. Progress in the two areas had not been equal, however, and current estimates suggested that the Millennium Development Goal targets for access to drinking-water would be achieved by 2015, while those for access to sanitation would not. Despite its critical importance, sanitation continued to receive less

funding and attention than water supply. Governments and donors should ensure that sanitation activities were at least as well funded as activities relating to water supply. A modern world needed sanitation, and sanitation required time, effort and resources.

Ms Chun-Ying HUANG (Chinese Taipei) said that in recent years, various interventions had been implemented under Chinese Taipei's patient safety campaign, launched in 2002. Those activities had included creating a patient safety committee, setting goals for quality of medical care and patient safety, devising a patient safety reporting system, celebrating an annual patient safety week, and providing training and education.

Mr BESANÇON (International Pharmaceutical Federation), speaking at the invitation of the CHAIRMAN, congratulated the Secretariat and Member States for their efforts to promote the rational use of medicines and integrate the issue into national policy. As a follow-up to the meeting of ministers of health held in October 2012 during the Federation's centennial congress, the Ministry of Health of Ireland would be hosting, with WHO support, a symposium on responsible use of medicines on 30 August 2013 in Dublin.

Dr KIENY (Assistant Director-General) said that WHO was preparing a global report on patient safety in the context of universal health coverage that would be published in late 2014. Concerning the request for technical support from the delegate of Maldives, the Secretariat would be consulting with the Regional Office for South-East Asia in that regard. In response to a question from the delegate of Mauritius, she said that the resources and tools developed by the African Partnerships for Patient Safety were available on the WHO web site. In the context of the Programme budget 2014–2015 and in view of the current emphasis on universal health coverage, the Secretariat was in the process of reviewing people-centred integrated service delivery from the perspective of service quality and patient safety.

In respect of progress in the rational use of medicines, the Secretariat would be working to respond to the request that had been made for a report on antimicrobial resistance and suggestions for how to deal with it, to be submitted to the Executive Board at its 134th session in January 2014. The Secretariat also planned to integrate a specific module on antimicrobial resistance surveillance into the new global research and development observatory, as suggested by the delegates of the United States of America and Colombia. She had also taken note of the request to scale up support to Member States on rational use of medicines, in particular, in the areas of health technology assessment, accreditation, and strengthening of national pharmacies.

She thanked the delegate of South Africa for his positive comments concerning the topic of health policy and systems research strategy.

Dr BUSTREO (Assistant Director-General) noted that Member States had welcomed the establishment of a Gender, Equity and Human Rights unit as part of the Organization's overall reform. Bringing gender into the mainstream of activities across the Organization was a key priority for the Director-General and 120 focal points were now in place. Based on the analysis and assessment made under the United Nations system-wide approach on gender equality and the empowerment of women, the Secretariat had drawn up an action plan that included accountability indicators and a greater level of detail than in previous plans, which would be implemented shortly. Many Member States had highlighted the importance of developing an integrated strategy on gender, equity and human rights since those three cross-cutting issues were not just complementary, but synergistic. Analysis of the gender dimension would anchor the framework in a proper context of multiple inequalities, while analysis of the human rights dimension would help to identify appropriate accountability mechanisms and tools for policy dialogue. She looked forward to working with Member States on the strategy, which would shortly be submitted for consideration to the governing bodies.



Dr FUKUDA (Assistant Director-General) said that with regard to the question of drinking-water, sanitation and health, he had taken note of the comments on indicators for the post-2015 agenda. Responding to the comments made by the delegate of Bangladesh, he said that the cholera vaccine could be regarded as a cholera prevention approach in addition to clean water and sanitation. WHO was working to establish a cholera vaccine stockpile and was pursuing its efforts to set up a task force. The representative of the International Federation of Red Cross and Red Crescent Societies had pointed out that although progress was being made on water goals, progress on sanitation was lagging. WHO was collaborating with various partners to solve that problem. The Deputy Secretary-General of the United Nations had specifically identified the area of water and sanitation as a target for revitalization and renewed efforts in light of the 1000 days before the end of the Millennium Development Goals, and WHO was cooperating on that initiative.

In respect of the progress report on workers' health: global plan of action, he wished to thank the delegates of Indonesia, Italy and Liberia for pointing out the importance of occupational health. WHO recognized that many work settings presented dangerous conditions for workers, and that there was a need for increased awareness and attention to safety in such settings. The Organization was using primary health care as a strategic element towards achieving that goal. There had been general agreement among Member States on the need to reduce and eliminate asbestos-related disease, and he thanked the delegate of the Russian Federation for offering to share its research findings in that regard. A risk analysis conducted by WHO in conjunction with IARC, and made available to countries in 2011, had concluded that all forms of asbestos were carcinogenic, that no safe threshold had been identified, and that it was extremely difficult to control exposure to asbestos in the workplace.

Dr TROEDSSON (Executive Director, Office of the Director-General) said that linking progress reports to the programme budget, as had been suggested by several Member States, could be done simply and efficiently by systematically comparing the actions taken by the Secretariat to the programme budget outputs, and by comparing the current status referred to in the progress reports to programme budget outcomes. Information on those comparisons would be included in the progress reports.

**The Committee noted the progress reports.**

### **3. FOURTH REPORT OF COMMITTEE B (Document A66/72)**

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

Miss PACHAREEWAN PHUNGIL (Thailand) proposed two minor editorial amendments.

**The report, as amended, was adopted.<sup>1</sup>**

### **4. CLOSURE OF THE MEETING**

After the customary exchange of courtesies, the CHAIRMAN declared the work of Committee B completed.

**The meeting rose at 16:55.**

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<sup>1</sup> See page 312.



## **PART II**

### **REPORTS OF COMMITTEES**



The text of resolutions and decisions recommended in the reports of Committee A and Committee B and subsequently adopted by the Health Assembly has been replaced by the respective resolution or decision number (in square brackets). The verbatim records of the plenary meetings at which these reports were approved are available on the WHO website, official records page: <http://apps.who.int/gb/or/>.

## **COMMITTEE ON CREDENTIALS**

### **Report<sup>1</sup>**

[A66/64 – 21 May 2013]

The Committee on Credentials met on 21 May 2013. Delegates of the following Member States were present: Canada; Cook Islands; Malawi; Mali; Mongolia; Nicaragua; Republic of Moldova; Romania; Sri Lanka; Turkey; Uganda.<sup>2</sup>

The Committee elected the following officers: Dr R. Wimal Jayantha (Sri Lanka) – Chairman, and Ms Roxana Rotocol (Romania) – Vice-Chairman.

The Committee examined the credentials delivered to the Director-General in accordance with Rule 22 of the Rules of Procedure of the World Health Assembly. It noted that the Secretariat had found these credentials to be in conformity with the Rules of Procedure.

The credentials of the delegates of the Member States shown at the end of this report were found to be in conformity with the Rules of Procedure as constituting formal credentials; the Committee therefore proposes that the World Health Assembly should recognize their validity.

The Committee examined notifications from the Member State listed below, which, while indicating the names of the delegates concerned, could not be considered as constituting formal credentials in accordance with the provisions of the Rules of Procedure. The Committee therefore recommends to the World Health Assembly that the delegates of that Member State be provisionally seated with all rights in the Health Assembly pending the arrival of its formal credentials:

Micronesia (Federated States of)

Signed by the Officers of the Committee on Credentials, 21 May 2013:

Chairman: Dr R.W. Jayantha, Sri Lanka;

Vice-Chairman: Ms R. Rotocol, Romania

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<sup>1</sup> Approved by the Health Assembly at its sixth plenary meeting.

<sup>2</sup> See decision WHA66(1).

**States whose credentials it was considered should be recognized as valid** (see fourth paragraph above and decision WHA66(6)):

Afghanistan; Albania; Algeria; Andorra; Angola; Antigua and Barbuda; Argentina; Armenia; Australia; Austria; Azerbaijan; Bahamas; Bahrain; Bangladesh; Barbados; Belarus; Belgium; Belize; Benin; Bhutan; Bolivia (Plurinational State of); Bosnia and Herzegovina; Botswana; Brazil; Brunei Darussalam; Bulgaria; Burkina Faso; Burundi; Cambodia; Cameroon; Canada; Cape Verde; Central African Republic; Chad; Chile; China; Colombia; Comoros; Congo; Cook Islands; Costa Rica; Côte d'Ivoire; Croatia; Cuba; Cyprus; Czech Republic; Democratic People's Republic of Korea; Democratic Republic of the Congo; Denmark; Djibouti; Dominican Republic; Ecuador; Egypt; El Salvador; Equatorial Guinea; Eritrea; Estonia; Ethiopia; Fiji; Finland; France; Gabon; Gambia; Georgia; Germany; Ghana; Greece; Grenada; Guatemala; Guinea; Guinea-Bissau; Guyana; Haiti; Honduras; Hungary; Iceland; India; Indonesia; Iran (Islamic Republic of); Iraq; Ireland; Israel; Italy; Jamaica; Japan; Jordan; Kazakhstan; Kenya; Kiribati; Kuwait; Lao People's Democratic Republic; Latvia; Lebanon; Lesotho; Liberia; Libya; Lithuania; Luxembourg; Madagascar; Malawi; Malaysia; Maldives; Mali; Malta; Mauritania; Mauritius; Mexico; Monaco; Mongolia; Montenegro; Morocco; Mozambique; Myanmar; Namibia; Nepal; Netherlands; New Zealand; Nicaragua; Niger; Nigeria; Norway; Oman; Pakistan; Panama; Papua New Guinea; Paraguay; Peru; Philippines; Poland; Portugal; Qatar; Republic of Korea; Republic of Moldova; Romania; Russian Federation; Rwanda; Saint Kitts and Nevis; Saint Lucia; Samoa; San Marino; Sao Tome and Principe; Saudi Arabia; Senegal; Serbia; Seychelles; Sierra Leone; Singapore; Slovakia; Slovenia; Solomon Islands; Somalia; South Africa; South Sudan; Spain; Sri Lanka; Sudan; Suriname; Swaziland; Sweden; Switzerland; Syrian Arab Republic; Tajikistan; Thailand; The former Yugoslav Republic of Macedonia; Timor-Leste; Togo; Tonga; Trinidad and Tobago; Tunisia; Turkey; Turkmenistan; Tuvalu; Uganda; Ukraine; United Arab Emirates; United Kingdom of Great Britain and Northern Ireland; United Republic of Tanzania; United States of America; Uruguay; Uzbekistan; Vanuatu; Venezuela (Bolivarian Republic of); Viet Nam; Yemen; Zambia; Zimbabwe.

## GENERAL COMMITTEE

### Report<sup>1</sup>

#### **Election of Members entitled to designate a person to serve on the Executive Board**

At its meeting on 22 May 2013, the General Committee, in accordance with Rule 100 of the Rules of Procedure of the World Health Assembly, drew up the following list of 12 Members, in the English alphabetical order, to be transmitted to the Health Assembly for the purpose of the election of the 12 Members to be entitled to designate a person to serve on the Executive Board: Albania, Andorra, Argentina, Brazil, Democratic People's Republic of Korea, Egypt, Japan, Namibia, Republic of Korea, Saudi Arabia, South Africa, and Suriname.

In the General Committee's opinion these 12 Members would provide, if elected, a balanced distribution on the Board as a whole.

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<sup>1</sup> Approved by the Health Assembly at its eighth plenary meeting, see decision WHA66(7).

## COMMITTEE A

### First report<sup>1</sup>

[A66/63 – 21 May 2013]

Committee A held its second and third meetings on 21 May 2013. These meetings were held under the chairmanship of Dr Walter T. Gwenigale (Liberia).

It was decided to recommend to the Sixty-sixth World Health Assembly the adoption of three resolutions and one decision relating to the following agenda items:

- 11. WHO reform [WHA66(8)]
- 12. Programme and budget matters
  - 12.2 Draft twelfth general programme of work [WHA66.1]
  - 12.3 Proposed programme budget 2014–2015 [WHA66.2]
- 21. Financial matters
  - 21.6 Amendments to the Financial Regulations and Financial Rules [WHA66.3].

### Second report<sup>1</sup>

[A66/65 – 22 May 2013]

Committee A held its fifth meeting on 22 May 2013. The meeting was held under the chairmanship of Dr Walter T. Gwenigale (Liberia) and vice-chairmanship of Dr Lester Ross (Solomon Islands).

It was decided to recommend to the Sixty-sixth World Health Assembly the adoption of one resolution relating to the following agenda item:

- 13. Noncommunicable diseases
  - 13.4 Draft action plan for the prevention of avoidable blindness and visual impairment 2014–2019 [WHA66.4].

### Third report<sup>2</sup>

[A66/69 – 23 May 2013]

Committee A held its seventh meeting on 23 May 2013. The meeting was held under the chairmanship of Dr Walter T. Gwenigale (Liberia).

It was decided to recommend to the Sixty-sixth World Health Assembly the adoption of one resolution relating to the following agenda item:

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<sup>1</sup> Approved by the Health Assembly at its eighth plenary meeting.

<sup>2</sup> Approved by the Health Assembly at its ninth plenary meeting.

- 14. Promoting health through the life course
  - 14.2 Follow-up actions to recommendations of the high-level commissions convened to advance women's and children's health [WHA66.7].

#### **Fourth report<sup>1</sup>**

[A66/70 – 24 May 2013]

Committee A held its eighth meeting on 24 May 2013. The meeting was held under the chairmanship of Dr Walter T. Gwenigale (Liberia) and vice-chairmanship of Dr Lester Ross (Solomon Islands).

It was decided to recommend to the Sixty-sixth World Health Assembly the adoption of two resolutions relating to the following agenda items:

- 13. Noncommunicable diseases
  - 13.3 Draft comprehensive mental health action plan 2013–2020 [WHA66.8]
  - 13.5 Disability [WHA66.9].

#### **Fifth report<sup>1</sup>**

[A66/73 – 27 May 2013]

Committee A held its twelfth meeting on 27 May 2013. This meeting was held under the chairmanship of Dr Walter T. Gwenigale (Liberia).

It was decided to recommend to the Sixty-sixth World Health Assembly the adoption of three resolutions relating to the following agenda items:

- 13. Noncommunicable diseases
  - 13.1 Draft comprehensive global monitoring framework and targets for the prevention and control of noncommunicable diseases [WHA66.10]
  - 13.2 Draft action plan for the prevention and control of noncommunicable diseases 2013–2020 [WHA66.10]
- 14. Promoting health through the life course
  - 14.1 Monitoring the achievement of the health-related Millennium Development Goals [WHA66.11]
- 16. Communicable diseases
  - 16.2 Neglected tropical diseases [WHA66.12].

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<sup>1</sup> Approved by the Health Assembly at its ninth plenary meeting.



**COMMITTEE B****First report<sup>1</sup>**

[A66/66 – 22 May 2013]

Committee B held its first meeting on 22 May 2013 under the chairmanship of Mrs Kathryn Tyson (United Kingdom of Great Britain and Northern Ireland).

In accordance with Rule 34 of the Rules of Procedure of the World Health Assembly, the Committee elected Dr Daisy Corrales Díaz (Costa Rica) and Dr Poonam Khetrpal Singh (India) Vice-Chairmen, and Mr Jilali Hazim (Morocco) Rapporteur.

It was decided to recommend to the Sixty-sixth World Health Assembly the adoption of two resolutions relating to the following agenda items:

- 20. Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan [WHA66.5]
- 21. Financial matters
  - 21.1 Financial report and audited financial statements for the period 1 January 2012–31 December 2012 [WHA66.6].

**Second report<sup>2</sup>**

[A66/68 – 23 May 2013]

Committee B held its second and third meetings on 23 May 2013 under the chairmanship of, respectively, Mrs Kathryn Tyson (United Kingdom of Great Britain and Northern Ireland) and Dr Poonam Khetrpal Singh (India).

It was decided to recommend to the Sixty-sixth World Health Assembly the adoption of nine resolutions and one decision relating to the following agenda items:

- 21. Financial matters
  - 21.2 Status of collection of assessed contributions, including Member States in arrears in the payment of their contributions to an extent that would justify invoking Article 7 of the Constitution [WHA66.13]
  - 21.3 Special arrangements for settlement of arrears [WHA66.14]
  - 21.4 Scale of assessments for 2014–2015 – Report of the Director-General [WHA66.15]
  - 21.4 Scale of assessments for 2014–2015 – Foreign exchange risk management [WHA66.16]
- 22. Audit and oversight matters
  - 22.1 Report of the External Auditor [WHA66.17]
- 23. Staffing matters
  - 23.5 Appointment of representatives to the WHO Staff Pension Committee [WHA66(11)]

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<sup>1</sup> Approved by the Health Assembly at its eighth plenary meeting.

<sup>2</sup> Approved by the Health Assembly at its ninth plenary meeting.

- 24. Management and legal matters
  - 24.1 Follow-up of the report of the Working Group on the Election of the Director-General of the World Health Organization [WHA66.18]
  - 24.2 Real estate [WHA66.19]
  - 24.3 Agreements with intergovernmental organizations [WHA66.20]
  - 24.4 Reassignment of South Sudan from the Eastern Mediterranean Region to the African Region [WHA66.21].

### **Third report<sup>1</sup>**

[A66/71 – 24 May 2013]

Committee B held its fourth and fifth meetings on 24 May 2013 under the chairmanship, respectively, of Mrs Kathryn Tyson (United Kingdom of Great Britain and Northern Ireland) and Dr Poonam Khetrpal Singh (India).

It was decided to recommend to the Sixty-sixth World Health Assembly the adoption of one decision relating to the following agenda item:

- 17. Health systems
  - 17.1 Substandard/spurious/falsely-labelled/falsified/counterfeit medical products [WHA66(10)].

### **Fourth report<sup>1</sup>**

[A66/72 – 27 May 2013]

Committee B held its sixth meeting on 27 May 2013 under the chairmanship, respectively, of Mrs Kathryn Tyson (United Kingdom of Great Britain and Northern Ireland), Dr Poonam Khetrpal Singh (India) and Dr Daisy Corrales Díaz (Costa Rica).

It was decided to recommend to the Sixty-sixth World Health Assembly the adoption of three resolutions and one decision relating to the following agenda items:

- 17. Health systems
  - 17.2 Follow-up of the report of the Consultative Expert Working Group on Research and Development: Financing and Coordination [WHA66.22 and WHA66(12)]
  - 17.3 Universal health coverage [WHA66.23]
  - 17.5 eHealth and health Internet domain names [WHA66.24].

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<sup>1</sup> Approved by the Health Assembly at its ninth plenary meeting.

## **LIST OF PARTICIPANTS**



## **MEMBERSHIP OF THE HEALTH ASSEMBLY COMPOSITION DE L'ASSEMBLEE DE LA SANTE**

### **LIST OF DELEGATES AND OTHER PARTICIPANTS LISTE DES DELEGUES ET AUTRES PARTICIPANTS**

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**THE GLOBAL FUND TO FIGHT AIDS,  
TUBERCULOSIS AND MALARIA – LE  
FONDS MONDIAL DE LUTTE CONTRE  
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