



WORLD HEALTH ORGANIZATION

SIXTY-SEVENTH WORLD HEALTH ASSEMBLY

GENEVA, 19–24 MAY 2014

SUMMARY RECORDS OF COMMITTEES

**REPORTS OF COMMITTEES
LIST OF PARTICIPANTS**

**GENEVA
2014**

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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PREFACE

The Sixty-seventh World Health Assembly was held at the Palais des Nations, Geneva, from 19 to 24 May 2014, in accordance with the decision of the Executive Board at its 133rd session.¹

¹ Decision EB133(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 133rd and 134th sessions
3. Address by Dr Margaret Chan, Director-General
4. Invited speaker
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6. Executive Board: election
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11. WHO reform
 - 11.1 Progress report on reform implementation
 - 11.2 Improved decision-making by the governing bodies

¹ Adopted at the second plenary meeting.

² Including election of Vice-Chairmen and the Rapporteur.

- 11.3 Framework of engagement with non-State actors
- 11.4 Follow-up to the financing dialogue
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- 12. Communicable diseases
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 - 13.1 Prevention and control of noncommunicable diseases
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 - Consideration of:
 - Terms of reference for the global coordination mechanism on the prevention and control of noncommunicable diseases
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- N. Multilingualism: implementation of action plan (resolution WHA61.12)

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 - 20.3 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
 - 20.4 [Deleted]
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¹ Including election of Vice-Chairmen and the Rapporteur.

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- 21. Audit and oversight matters
 - 21.1 Report of the External Auditor
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 - 22.1 Human resources: annual report
 - 22.2 Report of the International Civil Service Commission
 - 22.3 Amendments to the Staff Regulations and Staff Rules
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- 23. Management and legal matters
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 - 23.2 Real estate: update on the Geneva buildings renovation strategy
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A67/2	Report of the Executive Board on its 133rd and 134th sessions
A67/3	Address by Dr Margaret Chan, Director-General, to the Sixty-seventh World Health Assembly
A67/4	Progress report on reform implementation
A67/5	Improved decision-making by the governing bodies ²
A67/5 Add.1	Report on financial and administrative implications for the Secretariat of resolutions proposed for adoption by the Executive Board or Health Assembly ³
A67/6	Framework of engagement with non-State actors
A67/7	Follow-up to the financing dialogue
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A67/9	Strategic resource allocation Report of the Programme, Budget and Administration Committee of the Executive Board to the Sixty-seventh World Health Assembly
A67/10	Financing of administrative and management costs
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A67/12	Global vaccine action plan
A67/13	Improving the health of patients with viral hepatitis
A67/13 Add.1	Report on financial and administrative implications for the Secretariat of resolutions proposed for adoption by the Executive Board or Health Assembly ³

¹ See page xi.

² See document WHA67/2014/REC/1, Annex 2.

³ See document WHA67/2014/REC/1, Annex 6.

⁴ See document WHA67/2014/REC/1, Annex 1.

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A67/14 Add.1	Terms of reference for the global coordination mechanism on the prevention and control of noncommunicable diseases
A67/14 Add.2	High-level meeting of the United Nations General Assembly
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A67/16	Draft WHO global disability action plan 2014–2021: Better health for all people with disability ¹
A67/17	Comprehensive and coordinated efforts for the management of autism spectrum disorders
A67/17 Add.1	Report on financial and administrative implications for the Secretariat of resolutions proposed for adoption by the Executive Board or Health Assembly ²
A67/18	Psoriasis
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A67/19	Monitoring the achievement of the health-related Millennium Development Goals
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A67/21 and A67/21 Corr.1	Newborn health: draft action plan ³
A67/22	Addressing the global challenge of violence, in particular against women and girls, and against children
A67/23	Multisectoral action for a life course approach to healthy ageing
A67/24	Public health impacts of exposure to mercury and mercury compounds: the role of WHO and ministries of public health in the implementation of the Minamata Convention

¹ See document WHA67/2014/REC/1, Annex 3.

² See document WHA67/2014/REC/1, Annex 6.

³ See document WHA67/2014/REC/1, Annex 4.

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A67/25	Contributing to social and economic development: sustainable action across sectors to improve health and health equity
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A67/28	Follow-up of the report of the Consultative Expert Working Group on Research and Development: Financing and Coordination Health research and development demonstration projects
A67/28 Add.1	Meetings of stakeholders for selected health research and development demonstration projects, 7–10 May 2014
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A67/31	Strengthening of palliative care as a component of integrated treatment throughout the life course
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A67/37	Smallpox eradication: destruction of variola virus stocks
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¹ See document WHA67/2014/REC/1, Annex 5.

A67/40	Progress reports
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A67/58	Report of the External Auditor Report of the Programme, Budget and Administration Committee of the Executive Board to the Sixty-seventh World Health Assembly
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Information documents

A67/INF./1	Reform implementation plan
A67/INF./2	Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan Statement of the Government of Israel
A67/INF./3	Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan Report by the Ministry of Health of the Syrian Arab Republic
A67/INF./4	Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan Report of the Director of Health, UNRWA
A67/INF./5	Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan Report at the request of the Permanent Observer of Palestine to the United Nations and Other International Organizations at Geneva

Diverse documents

A67/DIV./1 Rev.1	List of delegates and other participants
A67/DIV./2	Guide for delegates to the World Health Assembly
A67/DIV./3	Decisions and list of resolutions
A67/DIV./4	List of documents
A67/DIV./5	Address by Her Excellency Dr Christine Kaseba-Sata, First Lady of the Republic of Zambia, to the Sixty-seventh World Health Assembly
A67/DIV./6	Address by Melinda Gates, Bill & Melinda Gates Foundation, to the Sixty-seventh World Health Assembly

OFFICERS OF THE HEALTH ASSEMBLY AND MEMBERSHIP OF ITS COMMITTEES

President

Dr Roberto MORALES OJEDA (Cuba)

Vice-Presidents

Dr Neil SHARMA (Fiji)

Mr François IBOVI (Congo)

Mr Maithripala Yapa SIRISENA (Sri Lanka)

Dr Vytenis Povilas ANDRIUKAITIS (Lithuania)

Mr Sadiq bin Abdul Karim AL-SHEHABI (Bahrain)

Secretary

Dr Margaret CHAN, Director-General

Committee on Credentials

The Committee on Credentials was composed of delegates of the following Member States: Chile, Democratic People's Republic of Korea, Dominican Republic, Ethiopia, Iceland, Iraq, Japan, Malaysia, Monaco, Mozambique, Portugal and Zambia

Chairman: Dr Feisul Idzwan MUSTAPHA (Malaysia)

Vice-Chairman: Dr Guy FONES (Chile)

Secretary: Mr Xavier DANEY (Senior 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: Afghanistan, Angola, Benin, Cabo Verde, China, Costa Rica, Equatorial Guinea, France, Greece, Guyana,

Republic of Korea, Russian Federation, Timor-Leste, Tunisia, United Kingdom of Great Britain and Northern Ireland, United States of America and Uruguay

Chairman: Dr Roberto MORALES OJEDA (Cuba)

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 Pamela RENDI-WAGNER (Austria)

Vice-Chairmen: Professor PE THET KHIN (Myanmar) and Dr Jorge VILLAVICENCIO (Guatemala)

Rapporteur: Dr Helen MBUGUA (Kenya)

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

Committee B

Chairman: Dr Ruhakana RUGUNDA (Uganda)

Vice-Chairmen: Dr Mohsen ASADI-LARI (Islamic Republic of Iran) and Dr Siale AKAUOLA (Tonga)

Rapporteur: Dr Dipendra Raman SINGH (Nepal)

Secretary: Dr Clive ONDARI, Coordinator, Safety and Vigilance

REPRESENTATIVES OF THE EXECUTIVE BOARD

Professor Jane HALTON (Australia)

Professor Ogtay SHIRALIYEV (Azerbaijan)

Dr Mohsen ASADI-LARI (Islamic Republic of Iran)

Professor PE THET KHIN (Myanmar)

PART I

SUMMARY RECORDS OF MEETINGS OF COMMITTEES

GENERAL COMMITTEE

FIRST MEETING

Monday, 19 May 2014, at 10:30

Chairman: Dr R. MORALES OJEDA (Cuba)
President of the World Health Assembly

1. ADOPTION OF THE AGENDA: Item 1.4 of the Agenda (Document A67/1)

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 four items included on the provisional agenda prepared by the Executive Board (document A67/1): item 5, Admission of new Members and Associate Members; item 20.4, Special arrangements for settlement of arrears; item 20.5, Assessment of new Members and Associate Members; and item 20.6, Amendments to the Financial Regulations and Financial Rules, as, in each case, the status quo had remained unchanged.

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 A67/1 and A67/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. He suggested that, given the heavy agenda, the Committee should review the progress of work. Arrangements had been made to allow the prolongation of the afternoon plenary meetings on Monday, 19 May and Tuesday, 20 May, so that Committee B might begin its work on the afternoon of Wednesday, 21 May. In the absence of any objection, he took it that the Committee endorsed those arrangements.

It was so agreed.

The General Committee then drew up the programme of work for the Health Assembly until Wednesday, 21 May.

The CHAIRMAN drew attention to decision EB134(14), whereby the Executive Board had decided that the Sixty-seventh World Health Assembly should close no later than Saturday, 24 May 2014. He took it that the proposal was acceptable.

It was so agreed.

The CHAIRMAN, referring to the list of speakers for the debate on item 3, 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 in 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 10:40.

SECOND MEETING

Wednesday, 21 May 2014, at 17:35

Chairman: Dr R. MORALES OJEDA (Cuba)
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 A67/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 10 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 10 Members whose term of office would expire at the end of the Sixty-seventh World Health Assembly and which would have to be replaced. The second (document A67/GC/2) contained a list, by region, of the 10 Members that it was suggested should be entitled to designate a person to serve on the Executive Board. Vacancies, by region, were: Africa, 4; the Americas, 1; South-East Asia, 1; Europe, 2; the Eastern Mediterranean, 1; and the Western Pacific, 1.

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 10 Members to the Health Assembly for the annual election of Members entitled to designate a person to serve on the Executive Board: China, Democratic Republic of the Congo, Eritrea, Gambia, Kuwait, Liberia, Nepal, Russian Federation, United Kingdom of Great Britain and Northern Ireland, and United States of America.

It was so agreed.

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

Dr RENDI-WAGNER (Austria), Chairman of Committee A, and Dr RUGUNDA (Uganda), Chairman of Committee B, reported on the progress of the work of their respective committees.

The CHAIRMAN proposed to transfer agenda item 15, Health systems, from Committee A to Committee B.

It was so decided.

He then proposed a programme of work for Thursday, 22 May, for Friday, 23 May and for Saturday, 24 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 General Committee drew up the programme of work for Thursday, 22 May; for Friday, 23 May; and for Saturday, 24 May.

The meeting rose at 17:40.

COMMITTEE A

FIRST MEETING

Monday, 19 May 2014, at 15:35

Chairman: Dr P. RENDI-WAGNER (Austria)

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

The CHAIRMAN welcomed participants and introduced the representatives of the Executive Board, Professor Jane Halton (Australia), Professor Ogtay Shiraliyev (Azerbaijan), Dr Mohsen Asadi-Lari (Islamic Republic of Iran) and Professor Pe Thet Khin (Myanmar),¹ 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 Professor Pe Thet Khin (Myanmar) and Dr Jorge Villavicencio (Guatemala) had been nominated as Vice-Chairmen and Dr Helen Mbugua (Kenya) as Rapporteur.

Decision: Committee A elected Professor Pe Thet Khin (Myanmar) and Dr Jorge Villavicencio (Guatemala) as Vice-Chairmen and Dr Helen Mbugua (Kenya) as Rapporteur.²

2. ORGANIZATION OF WORK

The CHAIRMAN said that, in view of the lengthy agenda before the Committee, delegates should limit their statements to three minutes and keep to the topic under discussion. 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. With the Committee's permission, the Director-General of the Food and Agriculture Organization of the United Nations would make a statement at the commencement of the discussion on agenda item 13.2 on Maternal, infant and young child nutrition.

It was so agreed.

Ms KEKEMPANOU (Greece) recalled that, following an exchange of letters in 2000 between WHO and the European Commission, the European Union had participated in the World Health Assembly as an observer. She requested that it should again be invited by the Committee to

¹ Participating by virtue of Rules 42 and 43 of the Rules of Procedure of the World Health Assembly.

² Decision WHA67(5).

participate, without vote, in the deliberations of the meetings of subcommittees, drafting groups and other subdivisions dealing with matters falling within the competence of the European Union.

The CHAIRMAN took it that the Board wished to accede to the request.

It was so agreed.

3. PROMOTING HEALTH THROUGH THE LIFE COURSE: Item 14 of the Agenda

Addressing the global challenge of violence, in particular against women and girls: Item 14.3 of the Agenda (Document A67/22)

Mr McIFF (United States of America) drew the Committee's attention to a draft resolution that related to the agenda item. With the Committee's permission, he would update participants on the informal process that had led to the draft resolution. He asked for a drafting group to be established to conclude the consultations on the agenda item before the end of the week.

Dr CHIKAMATA (Zambia) added that the following countries had proposed the draft resolution on strengthening the role of the health system in addressing violence, [in particular] against women and girls: Albania, Australia, Belgium, Canada, Guatemala, India, Italy, Latvia, Mexico, Namibia, Netherlands, Norway, Paraguay, Portugal, Republic of Moldova, Switzerland, Thailand, Turkey, Ukraine, United States of America, Uruguay and Zambia. The text read as follows:

The Sixty-seventh World Health Assembly,

PP1 Having considered the report on addressing the global challenge of violence, in particular against women and girls;¹

PP2 Recalling resolution WHA49.25 (1996), which declared violence a leading worldwide public health problem, resolution WHA56.24 (2003) on implementing the recommendations of the *World report on violence and health*, and resolution WHA61.16 (2008) on the elimination of female genital mutilation, and calling on Member States to improve health systems' responses to addressing [interpersonal] violence as part of a comprehensive collaborative multisectoral response;

PP3 Cognizant of the many efforts across the United Nations system to address the challenge of violence, in particular against women and girls, including the International Conference on Population and Development, the Beijing Declaration and Platform for Action, and all relevant United Nations General Assembly and Human Rights Council resolutions, as well as all relevant Commission on the Status of Women agreed conclusions;

PP4 [Recalling the Declaration on the Elimination of Violence against Women² which states that violence against women includes "any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life", and further "that violence against women includes, but is not limited to, the following: physical, sexual and psychological violence occurring in the family, including battering, sexual abuse of female children in the household, dowry-related violence, [marital rape,] female genital mutilation and other traditional practices harmful to women, non-spousal violence and violence related to exploitation; physical, sexual and psychological violence

¹ Document A67/22.

² United Nations General Assembly resolution 48/104.

occurring within the general community, including rape, sexual abuse, sexual harassment and intimidation at work, in educational institutions and elsewhere, trafficking in women and [forced] prostitution; and physical, sexual and psychological violence perpetrated or condoned by the State, wherever it occurs”]; [(NOTE: ADD LANGUAGE FROM paragraph 4.9 of ICPD Programme of Action on trafficking of women AND sexual exploitation of women)]

PP5 Concerned that the health of millions of people is adversely affected by [interpersonal] violence and that many cases go unreported;

PP6 Further concerned that the health-related consequences of [interpersonal] violence include death, disability and physical injuries, mental health sequelae and sexual and reproductive health consequences (e.g. sexually transmitted infections, HIV/AIDS, unwanted pregnancies, and pregnancy complications), as well as changes in behaviour such as increased tobacco consumption and harmful use of alcohol;

PP7 Recognizing that health systems often are not adequately addressing the problem of [interpersonal] violence and contributing to a comprehensive multisectoral response;

PP8 Deeply concerned that globally, one in three women experience either physical and/or sexual intimate partner violence or non-partner sexual violence at least once in their lives;¹

PP9 [Concerned that [interpersonal] violence, in particular against women and girls may also be exacerbated in situations of humanitarian emergencies, including as a result of armed conflicts];

PP10 Acknowledging that child, [early] and forced marriage is a matter of great concern² and that it can lead to profoundly negative health outcomes for women and girls;

PP11 Deeply concerned that many people have been affected by violence during childhood and noting that preventing [interpersonal] violence against children – boys and girls – can contribute significantly to preventing [interpersonal] violence against women and girls, that being abused and neglected during infancy and childhood makes it more likely that people will grow up to perpetrate [interpersonal] violence against women, maltreat their own children, and engage in youth violence, and increases the chances that girls will grow up to become victims of male [interpersonal] violence and perpetrators of child maltreatment, and underscoring that there is good evidence for the effectiveness of parenting support programmes in preventing child abuse and neglect in order to halt the intergenerational perpetuation of interpersonal violence;

PP12 Noting also that violence against girls needs specific attention because they are subjected to forms of violence related to gender inequality that too often remain hidden and unrecognized by society, including by health providers, and while child abuse (physical, emotional) and neglect affects boys and girls equally, girls suffer more sexual violence;

PP13 Deeply concerned that violence against women during pregnancy has grave consequences on the health of both the woman and the pregnancy, such as miscarriage and premature labour, and for the baby such as low birth weight, as well as the opportunity that antenatal care provides for early identification, [mitigation of consequences,] and prevention of recurrence of such [interpersonal] violence;

PP14 Concerned that children, particularly in child-headed households, are vulnerable to [all forms of]/[interpersonal] violence, including physical, sexual and emotional violence, and reaffirming the need to take action across sectors at national and international levels to promote the safety, support, protection, health care and empowerment of children, especially girls in child-headed households;

¹ Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence. WHO, 2013.

² As expressed in resolution A/RES/68/148 on this issue which was adopted by consensus, as well as resolution 24/23 of the Human Rights Council.

PP15 Recognizing that [boys and young men are]/[youth are] among those most affected by [interpersonal] violence, and that [interpersonal] violence contributes greatly to the global burden of premature death, injury and disability, particularly for young men, and has a serious and often lifelong impact on a person's psychological and social functioning, resulting in close links between youth violence, including bullying [and other forms of violence] throughout the life course;

PP16 Noting that violence is defined by [WHO]/[WHO World report on violence and health] [endorsed by the World Health Assembly] as "the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation;¹"

PP17 Considering that [FOOTNOTE] [, according to the 2002 WHO World report on violence and health,] interpersonal violence, distinguished from self-inflicted violence and collective violence, is divided into family and intimate partner violence and community violence, and includes forms of violence throughout the life course, such as child abuse, intimate partner violence, abuse of the elderly, family members, youth violence, random acts of violence, rape or sexual assault and violence in institutional settings such as schools, workplaces, prisons and nursing homes [and that interpersonal violence can be exacerbated during humanitarian crises and post-conflict situations;²]

PP18 [Deeply concerned that [interpersonal] violence, in particular against women and girls, persists in every country in the world as a major global challenge to public health, a pervasive violation of the enjoyment of human rights and a major impediment to achieving gender equality, sustainable development, peace and the internationally agreed development goals, in particular the Millennium Development Goals;]

PP19 [Recognizing that violence against women and girls is a form of discrimination and that power imbalances and structural inequality between men and women are among its root causes, and that effective addressing of violence against women and girls requires action at all levels of government, the engagement of civil society, the involvement of men and boys and the adoption and implementation of multifaceted and comprehensive approaches that promote gender equality and empowerment of women and [girls] that change harmful attitudes, customs, practices and stereotypes;]

PP20 [Aware that the process under way for the post-2015 development agenda can contribute to addressing, [from a health perspective the] [the root causes and health consequences of] violence [, in particular against women and girls] through a comprehensive and multisectoral response, [in particular violence against women and girls,] including as it relates to gender equality and empowerment of women [and girls], [and to building critical mass in setting the envisaged transformative actions in motion];]

PP21 Acknowledging also the many regional, subregional and national efforts aimed at coordinating prevention and response by health systems, to [interpersonal] violence, in particular against women and girls and against children;

¹ World report on violence and health. Geneva: World Health Organization; 2002.

² Page 6, World report on violence and health. Geneva: World Health Organization; 2002.

PP22 Noting with great appreciation the leading role WHO has played in establishing the evidence base on the magnitude, risk and protective factors,¹ consequences, prevention of and response to [interpersonal] violence,² in particular against women and girls,³ in the development of norms and standards, in advocacy and in supporting efforts to strengthen research, prevention programmes and services for [those affected by]/[victims of] [interpersonal] violence; that this work is carried out mainly by the Department of Violence and Injury Prevention and Disability, the Department of Reproductive Health and Research,⁴ the Department for Mental Health and Substance Dependence and the Department for Emergency Risk Management and Humanitarian Response, in close collaboration with Regional and Country Offices and that addressing violence, in particular against women and girls, is a component of WHO's work to address the health-related Millennium Development Goals and the social, economic and environmental determinants of health which are leadership priorities within the WHO Twelfth General Programme of Work 2014–2019;

PP23 Recognizing the need to scale up [interpersonal] violence prevention policies and programmes to which the health system contributes and that while some evidence-based guidance exists on effective interventions, more research and evaluation of these and other interventions is required;

PP24 Stressing the importance of preventing [interpersonal] violence before it begins or reoccurs, and noting that the role of the health system in the prevention of violence, in particular against women and girls, includes supporting efforts to: reduce child maltreatment, such as through parenting support programmes; address substance abuse including the harmful use of alcohol; prevent the reoccurrence of violence by providing health and psychosocial care and/or rehabilitation for victims and perpetrators and to those who have witnessed violence; and, collect and disseminate evidence on the effectiveness of prevention and response interventions;

PP25 Recalling the health system's role in advocating, as an element of prevention, for interventions to combat the social acceptability and tolerance of interpersonal violence, in particular against women and girls [emphasizing the role of Member States in promoting societal transformation];

PP26 Recognizing that [interpersonal] violence, in particular against women and girls, can occur within the health system itself, which can negatively impact the health workforce, the quality of health care provided and lead to disrespect and abuse of patients, and discrimination to access of services provided;

PP27 Affirming the unique and important leadership role that health systems must play in identifying and documenting incidents of [interpersonal] violence, and providing clinical care and appropriate referrals for those affected by such incidents, particularly women and girls, as well as contributing to prevention and advocating within governments and among all stakeholders for an effective, comprehensive, multi-sectorial response to [interpersonal] violence;

¹ Protective factors are those that decrease or buffer against the risk of violence. While much of the research on violence against women and violence against children has focused on risk factors, it is important for prevention also to understand protective factors. Prevention strategies and programmes aim to decrease risk factors and/or to enhance protective factors.

² [Including the] World report on violence and health (2002).

³ [Including the] WHO Multi-country Study on Women's Health and Domestic Violence against Women (2005); Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence (2013); Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines (2013).

⁴ Including the contribution of the UNDP/UNFPA/UNICEF/WHO/World Bank Special Programme of Research, Development and Research Training on Human Reproduction to research on violence against women and girls.

PP28 [Noting that the implementation of the recommendations contained in this resolution is the sovereign right of each country consistent with national laws and development priorities, with full respect for the various religious and ethical values and cultural backgrounds of its people and in conformity with universally recognized international human rights. (Source: United Nations, 1994. Programme of action adopted at the International Conference on Population and Development, Cairo, 5–13 September 1994. Programme of Action of the International Conference on Population and Development, Chapter II, Principles);]

PP29 [Recalling that states are urged to strongly condemn all forms of violence against women and girls and to refrain from invoking any custom, tradition or religious consideration to avoid their obligations with respect to its elimination as set out in the Declaration on the Elimination of Violence against Women (Source: E/2013/27, E/CN.6/2013/11, Commission on the Status of Women, 57th session, Agreed Conclusions. Paragraph 14);]

PP30 [Recognizing that all human rights are universal, indivisible and interdependent and interrelated and that the international community must treat human rights globally in a fair and equal manner, on the same footing and with the same emphasis, and stresses that, while the significance of national and regional particularities and various historical, cultural and religious backgrounds must be borne in mind, it is the duty of States regardless of their political, economic and cultural systems to promote and protect all human rights and fundamental freedoms. (Source: Commission on the Status of Women, 58th session);]

(OP.1) [URGES Member States:¹]

OR

- (OP.1) [Requests Member States¹ within their national context:]
- (OP1.1) to strengthen the role of their health systems in addressing [interpersonal] violence,] [in particular] [violence] against women and [girls,] / [children] to ensure that all people at risk and or affected by violence have timely, effective, and affordable access to health services, including health promotion, curative, rehabilitation and support services that are free of abuse, disrespect and discrimination, to strengthen their contribution to prevention programmes and to support WHO's work related to this resolution;
 - (OP1.2) to ensure health system engagement with other sectors, such as education, justice, social services, women's affairs, and child development, in order to promote and develop an effective, comprehensive, national multi-sectorial [human rights-based]/[health-based] response to interpersonal violence, [in particular] against women and [girls,]/[children] by, inter alia, adequately addressing violence in health and development plans, establishing and adequately financing national multisectoral strategies on violence prevention and response including protection, as well as promoting inclusive participation of relevant stakeholders;
 - (OP1.3) to strengthen their health system's contribution to ending the acceptability and tolerance of all forms of violence against women and girls, including through advocacy, counselling and data collection, while promoting the age-appropriate engagement of men and boys alongside women and girls, as agents of change, in their family and community, so as to promote gender equality and the empowerment of women and girls;
 - (OP1.4) to improve collection and, as appropriate, dissemination of comparable data disaggregated for sex, age, and other relevant factors, on the magnitude, risk and, protective factors, types, and health consequences of [interpersonal] violence,

¹ And, where applicable, regional economic integration organizations.

[[in particular] against women and [girls,]]/[and violence against children] as well as information on best practices, including the quality of care and effective prevention and response strategies, to strengthen the national response;

(OP1.5) [to strengthen the role of their health systems in the promotion [and] [,] protection [and fulfilment] of [health-related] human rights, [including those related to sexual and reproductive health,] [and to realize their commitments relating to sexual and reproductive health] so as to contribute to multisectoral efforts in addressing interpersonal violence;] [NOTE: OR SPLIT GENERAL HUMAN RIGHTS FROM SEXUAL AND REPRODUCTIVE HEALTH]

(OP1.6) to seek to prevent reoccurrence and break the cycle of [interpersonal] violence, by strengthening, as appropriate, the timely access for victims, perpetrators and those affected by [interpersonal] violence to effective health, social and psychological services and to evaluate such programmes to assess their effectiveness in reducing reoccurrence of [interpersonal] violence;

(OP1.7) to enhance capacities, including through appropriate continuous training of all public and private professionals from health and non-health sectors, as well as caregivers and community health workers, to provide care and support, as well as other related preventive and health promotion services to victims and those affected by [interpersonal] violence, in particular women and girls;

(OP1.8) to promote, establish, support and strengthen standard operating procedures targeted to identify [interpersonal] violence against women and girls, and against children, taking into account the important role of the health system in providing care and making referrals to support services;

(OP1.9) [to [give due consideration]/[ensure that due consideration is given] to the importance of [health issues related to]/[the health system] preventing and responding to [interpersonal] violence, in particular violence against women and [girls] [and violence against children,] [including [child,] early, and forced marriage], [in the elaboration[s] of]/[in the discussions on] the post-2015 development agenda;] [NOTE: SUBJECT TO DELETION, FOLLOWING DISCUSSIONS ON THE CORRESPONDING PP]

OP2. REQUESTS the Director-General:

(OP2.1) [to develop, with the full participation of Member States,¹ and in collaboration with United Nations organizations, [relevant international organizations and other relevant stakeholders,] a draft global plan of action to strengthen the role of the health system[s] [within]/[in] a [national] multisectoral response [to address]/[in addressing] [all forms of] [interpersonal] violence, [in particular] [all forms of]/[against] [interpersonal] violence against women and [girls]/[as well as] [children, recognizing that girls need specific and different types of attention than boys]/[women and girls and [interpersonal] violence against children], building on existing relevant WHO work and complementing [national, regional and global] efforts by other organizations of the United Nations system] [, including UNWOMEN;]

(OP2.2) to include in the plan of action, [objectives, targets and indicators applicable to the [mandate of the] WHO Secretariat, Member States and [relevant] international partners], recognizing the importance of a one-WHO response to this work that incorporates all relevant [WHO] programmes [including the WHO Global Strategy to Reduce the Harmful Use of Alcohol, the WHO Global

¹ And, where applicable, regional economic integration organizations.

Comprehensive Mental Health Action Plan 2013–2020, and the WHO Reproductive Health Strategy];

(OP2.3) [to ensure the global plan of action adequately addresses the role of the health system and the [United Nations Humanitarian] [Global] Cluster on Health in tackling [interpersonal] violence against women and girls in humanitarian emergencies and post-conflict situations;]

(OP 2.4) to continue to strengthen WHO efforts [and its collaboration with other relevant stakeholders] to develop the scientific evidence base on the magnitude, consequences and risk [and protective] factors for [interpersonal] violence, in particular against women and girls, and on effective prevention and response interventions by: updating on a regular basis prevalence and health burden estimates [of violence against women and other forms of violence]; updating scientific reviews on the effectiveness of interventions to prevent and respond to [interpersonal] violence [in particular against women and girls]; and developing and implementing a research agenda on health system responses to [interpersonal] violence, including against women and girls and against children, [and in humanitarian settings;]

(OP2.5) to support Member States, upon their request, in developing, testing and implementing [the health aspects of national] [health policy] strategies to prevent and respond to [interpersonal] violence, in particular [violence] against women and girls and against children, and in providing other relevant health services, [, including sexual and reproductive health [services]/[care],] including by engaging other relevant sectors;

(OP2.6) to continue to support Member States, upon their request, in strengthening health system responses to [interpersonal] violence, in particular against women and girls and against children, including by supporting the development of curricula and training opportunities for health personnel and other health sector professionals to develop practices for early identification of cases of [interpersonal] violence and to address the health consequences of [interpersonal] violence;

(OP 2.7) [to support Member States in the development of methodologies of intervention in humanized health [prevention, promotion, support] care to victims of violence, particularly in cases of sexual violence, in order to minimize pain and suffering, to provide protection and to foster the recovery of their self-esteem, helping promote their reinsertion in the social and family environment];

(OP2.8) [to report to the Board at its 136th session on progress implementing this resolution, in particular the finalization in 2014 of a global status report on violence and health which is being developed in cooperation with UNDP and UNODC, and reflects national violence prevention efforts, as one input into the development of the draft global plan of action, and to report also to the Board at its 138th session on progress in implementing this resolution, including presentation of the draft global action plan, for consideration by the Sixty-ninth World Health Assembly.]

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

1. Resolution: Strengthening the role of the health system in addressing violence, [in particular] against women and girls									
2. Linkage to the Programme budget 2014–2015 (see document A66/7 http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_7-en.pdf) Category: 2. Noncommunicable diseases <table> <tr> <td>Programme area: Violence and injuries</td><td>Outcome: 2.3 Output: 2.3.3</td></tr> <tr> <td>Programme area: Mental health and substance abuse</td><td>Outcome: 2.2 Output: 2.2.2</td></tr> </table> Category: 3. Promoting health through the life course <table> <tr> <td>Programme area: Reproductive, maternal, newborn, child and adolescent health</td><td>Outcome: 3.1 Output: 3.1.4</td></tr> </table> Category: 5. Preparedness, surveillance and response <table> <tr> <td>Programme area: Emergency risk and crisis management</td><td>Outcome: 5.3 Output: 5.3.1</td></tr> </table> How would this resolution contribute to the achievement of the outcome(s) of the above programme area(s)? The resolution would contribute to bringing increased attention to bear on violence, in particular violence against women and girls, as a public health issue, on its severe health impacts and its preventability, and on the role that the health sector plays in tackling violence. It would further strengthen the health sector's role within a multisectoral response and provide committed policy-makers in the health sector with a stronger mandate for dealing with the topic. The resolution would also help to increase collaboration both between WHO and its external partners and within the Organization.		Programme area: Violence and injuries	Outcome: 2.3 Output: 2.3.3	Programme area: Mental health and substance abuse	Outcome: 2.2 Output: 2.2.2	Programme area: Reproductive, maternal, newborn, child and adolescent health	Outcome: 3.1 Output: 3.1.4	Programme area: Emergency risk and crisis management	Outcome: 5.3 Output: 5.3.1
Programme area: Violence and injuries	Outcome: 2.3 Output: 2.3.3								
Programme area: Mental health and substance abuse	Outcome: 2.2 Output: 2.2.2								
Programme area: Reproductive, maternal, newborn, child and adolescent health	Outcome: 3.1 Output: 3.1.4								
Programme area: Emergency risk and crisis management	Outcome: 5.3 Output: 5.3.1								
Does the programme budget already include the outputs and deliverables requested in this resolution? (Yes/no) Yes.									
3. Estimated cost and staffing implications in relation to the Programme budget (a) Total cost Indicate (i) the lifespan of the resolution during which the Secretariat's activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US\$ 10 000). (i) Five years (covering the period 2014–2018) (ii) Total: US\$ 34.65 million (staff: US\$ 18.81 million; activities: US\$ 15.84 million)									

(b) Cost for the biennium 2014–2015

Indicate how much of the cost indicated in 3(a) is for the biennium 2014–2015 (estimated to the nearest US\$ 10 000).

Total: US\$ 13.54 million (staff: US\$ 7.39 million; activities: US\$ 6.15 million)

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

All levels of the Organization.

Is the estimated cost fully included within the approved Programme budget 2014–2015? (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, for the biennium 2014–2015.

For the biennium 2016–2017 and beyond, additional staff might be needed, in particular at regional and country levels.

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.

The need for additional staff will depend on the development of the global plan of action requested in the resolution.

4. Funding

Is the estimated cost for the biennium 2014–2015 indicated in 3 (b) fully funded? (Yes/no)

No: approximately US\$ 5 million of the US\$ 13.54 million for the biennium have currently been secured.

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

For the biennium 2014–2015, the funding gap is approximately US\$ 8.54 million. It is envisaged that the gap will be closed through the financial dialogue process and coordinated resource mobilization efforts.

The sponsors had suggested the establishment of the drafting group mentioned by the delegate of the United States of America. A crucial area for deliberation was the request to the Director-General to develop a draft global plan of action to strengthen the role of health systems as part of a national response to address all forms of interpersonal violence. Participants in the informal consultations had found it beneficial to focus discussion initially on operative paragraphs, and then, once the scope of the draft was clear, to look at preambular paragraphs. If a drafting group were established, the Committee might wish to adopt a similar approach.

Dr GONZÁLEZ FERNÁNDEZ (Cuba) asked for confirmation that the Committee would start its work by considering agenda item 12.1 on tuberculosis, in accordance with the published schedule.

The CHAIRMAN gave that confirmation, but invited the chairman of the informal consultations to take the floor.

Mr McIFF (United States of America), explaining the reasons behind the proposal to establish a drafting group, said that, in line with decision EB134(6), the sponsors of the draft resolution had

worked throughout the intersessional period to improve the text, including six informal meetings. In view of the considerable efforts that had been made, it was to be hoped that all remaining issues could be resolved. Adoption of the resolution would be a significant achievement.

The CHAIRMAN took it that the Committee agreed to set up a drafting group to work further on the draft resolution under agenda item 14.3, with Mr Colin McIff (United States of America) and Dr Emmanuel Makasa (Zambia) as co-chairmen.

It was so agreed.

(For continuation of the discussion and approval of the draft resolution, see the summary record of the twelfth meeting, section 7.)

4. COMMUNICABLE DISEASES: Item 12 of the Agenda

Draft global strategy and targets for tuberculosis prevention, care and control after 2015: Item 12.1 of the Agenda (Documents A67/11 and EB134/2014/REC/1, resolution EB134.R4)

Dr ASADI-LARI (Islamic Republic of Iran, representative of the Executive Board) said that, at its 134th session, in January 2014, the Board had noted a report (document EB134/12) on the draft global strategy and targets for tuberculosis prevention, care and control after 2015. The discussion had in particular highlighted the problems of drug resistance, vulnerable populations and cross-border migrants. The Board had adopted resolution EB134.R4, which contained a draft resolution recommended to the Health Assembly for adoption.

Dr ASUNCION (Philippines) expressed her support for the draft global strategy. Her country had formulated a strategic plan incorporating the principles of the draft strategy in consultation with the public and private sectors and the community affected by tuberculosis. The country's 63-strong coalition of relevant stakeholders had significantly contributed to tuberculosis control and detection, particularly through the involvement of the private sector. Further efforts were, however, required in order to promote human rights, ethics and equity among high-risk populations, such as prison inmates, internally displaced persons and people living with HIV.

Mr DAVID (Australia) welcomed the ambitious yet achievable targets for 2020, 2025 and 2035 and strongly urged Member States to adopt the draft resolution.

Dr AL HAJERI (Bahrain) expressed full support for the draft strategy. It was vital to translate the draft into an overarching national multisectoral plan, taking into account national priorities, resource availability and the engagement of civil society and the private sector in implementation, with simultaneous provision of universal health coverage and sustainable financing policies. In order to reduce the incidence of tuberculosis, Bahrain had taken numerous measures, notably screening tuberculosis patients for HIV infection and people with HIV for tuberculosis, continuing development of laboratory testing, and detection of multidrug-resistant and extensively drug-resistant tuberculosis.

Dr MAAROUFI (Morocco) suggested that the global strategy should include the possibility of purchasing services from the private sector, a form of public-private partnership, as an effective way of easing the shortage of laboratory staff.

Dr NGUYEN VIET NHUNG (Viet Nam) said that his Government had already adapted the draft strategy for its national strategy for tuberculosis control, adopting the directly observed

treatment, short course (DOTS) strategy as a rational public health approach for tuberculosis control and facilitating the rapid introduction of new medicines and diagnostic tools. He urged Member States to endorse the draft strategy and support other Member States in reviewing, adopting and adapting their post-2015 tuberculosis strategies.

Dr AL RAND (United Arab Emirates) welcomed the draft strategy, with its milestones for 2025, targets for 2035 and the pillars and components of the new strategic framework. His country had adopted the DOTS strategy and introduced a screening programme for migrant workers. Thanks to the establishment of a case-registration system and a national testing laboratory, most cases had been detected and treated appropriately; access to treatment was guaranteed. A programme was also in place to raise awareness of the disease and its complications, and no effort would be spared in ensuring its rigorous implementation, particularly with regard to multidrug resistance and the ongoing review of the legislation governing the programme.

Ms WENDLING (Germany) expressed particular appreciation of the emphasis on tuberculosis and HIV coinfection and on surveillance of multidrug-resistant and extensively drug-resistant tuberculosis, as well as the call for universal health coverage and social protection mechanisms as fundamental means to control multidrug-resistant disease. Despite significant progress in most regions, tuberculosis remained a major public health problem throughout the world, including the countries of the European Region. Member States should invest more in prevention, early diagnosis and treatment as the most effective way to halt tuberculosis, and not overlook tuberculosis in children.

Dr Y. PILLAY (South Africa) said that the draft strategy was particularly important for countries facing the double burden of high tuberculosis and HIV prevalence rates, and urged all Member States to adopt and fully implement its provisions. In South Africa, where the decline in incidence of new infections was insufficient to meet targets, efforts had been made to strengthen the early detection and treatment of tuberculosis, especially in prisons and mining communities, and to decentralize and improve national prevention and treatment services for multidrug-resistant forms of the disease. GeneXpert technology had been made available in more than 300 laboratories nationwide and its diagnostic effectiveness was being evaluated. The Minister of Health, in his capacity as the Chair of the Stop TB Partnership Board, had welcomed the Secretariat's commitment actively to support the development of a global investment plan by the Stop TB Partnership. South Africa fully supported the draft global strategy and targets for tuberculosis prevention, care and control after 2015.

Ms WHITE (Canada) strongly supported the draft resolution and advocated increased access to quality-assured anti-tuberculosis medicines and innovative approaches to tuberculosis control. Canada had recently announced its backing of the Global Plan to Stop TB 2016–2020, which complemented the draft strategy. She urged all partners to commit sufficient financial resources to the draft strategy and WHO's anti-tuberculosis activities, as full funding would be required to reach the three million people infected with tuberculosis each year who remained undiagnosed or whose cases were unreported. She particularly welcomed the initiative in the draft strategy to improve tuberculosis screening among selected high-risk groups.

Mr ZHANG Yong (China) expressed broad support for the draft strategy but recommended improving its applicability to countries with a high burden of tuberculosis; providing such countries with further technical and financial assistance; and stepping up interagency efforts within the United Nations system to coordinate and boost the mobilization of resources.

Mr BARREIRA (Brazil), recognizing the importance of a multisectoral approach in achieving the new international goals for combating tuberculosis in the post-2015 period, drew attention to the need for better financing of research and development to ensure universal access to health. National discussions on combating tuberculosis should be widened to include social protection for people with

tuberculosis and innovative approaches to prevention and control. Three years before the 2015 deadline Brazil had achieved the Millennium Development Goal target for tuberculosis control, mainly because its public health policy was strongly influenced by a principle enshrined in the national Constitution that guaranteed health as a universal right and responsibility of the State. He called on Member States to adopt the draft resolution.

Dr KESETE-BIRHAN (Ethiopia), speaking on behalf of the Member States of the African Region, praised the vision and ambitious targets of the draft strategy and encouraged WHO to intensify its work on tuberculosis prevention, care and control in order to bring about a tuberculosis-free world. Tuberculosis remained a major public health problem in Africa, where nine of the 22 countries with a high burden of tuberculosis were located. In particular, HIV coinfection with tuberculosis posed a serious threat to tuberculosis control and elimination. The success of tuberculosis control depended on all persons affected receiving timely treatment without having to bear a heavy financial and social burden. In order to organize, expand and sustain integrated services for tuberculosis prevention, diagnosis, treatment and support, it would be necessary to strengthen health systems and social services in general and reach out to vulnerable populations. The Member States in the Region strongly supported the draft strategy and resolution. They called for special attention to the Region, particularly in the building of diagnostic and treatment capacity for multidrug-resistant tuberculosis. For the draft strategy to succeed, input must come from partners within and outside the health sector, with consolidated country ownership as its basic foundation. Full access to tuberculosis care, prevention and control must be seen by all as a basic human right, and the full commitment of all stakeholders was crucial for achieving the ambitious targets. He urged all stakeholders to demonstrate their commitment and cooperate to end the tuberculosis epidemic.

In the draft strategy, he proposed replacing the phrase “suspected tuberculosis” with “presumptive tuberculosis”, adding a glossary of terms used in the draft strategy and resolution, including definitions of all indicators, and revising four of the indicators: splitting “percentage of eligible people living with HIV and children aged under five who are contacts of tuberculosis patients being treated for latent tuberculosis infection” into two groups; specifying the population referred to and the method of measuring the “percentage of population without catastrophic health expenditures”; clarifying the meaning of “percentage of affected families facing catastrophic costs due to tuberculosis”; and clarifying “percentage of population without undernutrition”.

Mr ABDULLAYEV (Azerbaijan) offered his country’s full support for the draft strategy. Joint strategies, partnerships with international organizations and mobilizing the medical community had helped his Government to step up the fight against tuberculosis. Legislation and Ministry of Health decrees had created the legal foundations required to combat the illness. A national programme provided specific measures to strengthen the material and technical resources of institutions fighting tuberculosis. Outpatient networks had been expanded by using general practitioners to promote early detection, and a nationwide electronic registration system for people with tuberculosis had been introduced. The supply of first-line and second-line medicines was guaranteed for all patients. Future challenges included achieving comprehensive case detection; reducing the incidence of multidrug-resistant tuberculosis; setting clearer priorities; and encouraging unified interregional strategies that took into account geographical, climatic and epidemiological factors peculiar to the region.

Dr FERGUSON (Jamaica) remarked that some of the variables used to calculate the targets in the draft strategy failed to take into account countries’ cultural and political specificities. For example, the success of social protection schemes depended largely on translation of political commitment into financial commitment, and such schemes might not be culturally acceptable everywhere. Nevertheless, his country supported the draft strategy and affirmed the importance of accountability, monitoring and evaluation in tuberculosis prevention and care. His Government had already taken steps to incorporate such practices into its national tuberculosis strategy and had incorporated community cooperation and

human rights, ethics and equity protection measures in its social and health policies. He thanked the Secretariat for its ongoing technical support.

Ms MŪRMANE-UMBRAŠKO (Latvia) endorsed the main principles of the draft strategy and emphasized the threat posed to tuberculosis control by the emergence of multidrug-resistant tuberculosis. Latvia served as an example that the management of multidrug-resistant tuberculosis was feasible, efficient and cost-effective when implemented through the DOTS strategy. Progress towards the tuberculosis-related Millennium Development Goal target depended on strengthening health systems. Success of the draft strategy would require collaboration in tuberculosis monitoring and control mechanisms among high- and low-incidence countries, especially in view of the increasing levels of labour mobility and cross-border movement.

Dr AL-TAAE (Iraq) expressed support for the draft strategy and underlined the importance of prevention, early detection and treatment and of rejecting all stigmatization attached to tuberculosis. The draft strategy must take account of the social determinants of health and advocate healthy lifestyles. Emphasis must also be placed on the early detection and treatment of multidrug-resistant tuberculosis as part of primary health care and on the integration of the draft strategy into national development strategies. His Government was actively working along those lines, in conjunction with WHO and such international organizations as IMF and UNDP, as well as civil society organizations, in order to improve the quality of its indicators and benchmarks.

Mr MIŠKINIS (Lithuania) expressed dismay that tuberculosis remained a serious public health concern in many countries, including his own. Despite a steady decline in incidence, prevalence and mortality, Lithuania would not reach the tuberculosis-related target under Millennium Development Goal 6 by 2015. A new approach and tools were needed, and the draft strategy provided a clear vision for the coming decades. The target of ending the epidemic by 2035 was achievable and the draft strategy would be a constructive and powerful instrument in the progress towards that goal.

Dr BUGTI (Pakistan) said that her country had launched a free tuberculosis control programme treating more than two million cases; passed bills declaring tuberculosis a notifiable disease and regulating over-the-counter sales of anti-tuberculosis medicines; and established an electronic surveillance system to increase the availability of patient data. The foremost challenges were low patient compliance and stigmatization, both of which were being addressed through the DOTS strategy, with malnutrition and lowered immunity due to noncommunicable diseases also hindering progress. Although Pakistan supported the draft strategy, sustainable financing and research would be essential in the search for solutions to drug resistance.

Dr MMBANDO (United Republic of Tanzania) proposed that the phrase “characteristics and” in paragraph 83 of the draft strategy be deleted. Expressing concern at the scope of the social protection called for in the draft, given that many diseases besides tuberculosis also led to a loss of income, he proposed that the draft strategy be amended to limit such social protection solely to health sector interventions.

Dr USHIO (Japan) welcomed the fact that the new draft strategy indicated a more multilateral approach to tuberculosis measures. Strengthening tuberculosis initiatives within the framework of universal health coverage was at the root of Japan’s successful anti-tuberculosis measures, and the country would continue to provide technical assistance and training in such matters. Tuberculosis prevalence surveys suggested that many people remained undiagnosed and untreated. It was therefore vital to improve case identification by improving diagnostic equipment, promoting research and development and keeping the cost of services at a reasonable level. Constant attention should also be paid to increasing compliance with treatment and preventing the spread of multidrug-resistant tuberculosis.

Ms VINUESA SEBASTIÁN (Spain) said that the adoption and implementation of the draft strategy were crucial to ending the global tuberculosis epidemic by 2035. She expressed support for the draft strategy's provisions, including the special measures for vulnerable populations and early detection and treatment of tuberculosis to prevent multidrug-resistant disease. Her Government had recently revised its national tuberculosis prevention and control plan to bring it fully into line with the draft strategy's principles and goals.

Mr PABLOS-MENDEZ (United States of America) supported the draft strategy. Achieving the ambitious targets would need early detection of all tuberculosis cases, both drug-sensitive and drug-resistant, as well as outcome-oriented research, facilitated through multidisciplinary approaches. Some 2000 million people were currently estimated to be latently infected with tuberculosis, with activation potentially set off by comorbidities such as HIV infection. As such, tuberculosis prevention, care, and treatment needed to be included in both poverty-alleviation strategies and urban development. His country was prepared to do its part, in conjunction with the Global Fund to Fight AIDS, Tuberculosis and Malaria; however, high-burden countries, most of which were middle-income countries, should also provide domestic resources for programme implementation and research to enable targets to be reached.

Ms JESSE (Estonia) said that, although the draft strategy was comprehensive, the success of tuberculosis control would depend on timely treatment of all persons with tuberculosis, without imposition of a heavy financial or social burden, and completion of the course of treatment. High levels of multidrug-resistant tuberculosis in eastern European countries posed a serious threat to the goal of tuberculosis elimination in the region. In Estonia, 78% of patients who failed to complete treatment abused alcohol or drugs. Treatment was simultaneously offered for comorbidities, as recommended in the report. She supported the draft resolution.

Ms VACA (Colombia) pointed out that neither the draft strategy nor the draft resolution paid sufficient attention to the promotion of collaborative projects to identify innovative solutions for diagnostic testing and the treatment of multidrug-resistant disease. The draft strategy should be amended to cover the issues of collaboration, public investment, and research and development models which would make the price charged for the final product independent of the costs incurred for research.

Dr DOGBÉ (Togo) said that, since 2010, Togo had seen improvements in the indicators for incidence, loss to follow-up, morbidity and successful treatment outcomes in tuberculosis. Although a new plan for the period 2014–2019 based on WHO guidelines was currently at the drafting stage, it might prove difficult to raise the funds to implement it. He called on partners to assist his country to implement the plan and combat tuberculosis more effectively.

Dr BOUBAHRI (Tunisia) welcomed the advances made in all regions in combating tuberculosis and the satisfactory progress as measured by the indicators for detection and treatment. That progress was offset, however, by the rising number of cases of HIV-associated and multidrug-resistant tuberculosis, the emergence of extensively drug-resistant tuberculosis and the growing global burden of the disease, which also complicated attainment of the targets set for 2015. Elaborated through the efforts and wide-ranging consultative process led by WHO's Strategic and Technical Advisory Group for Tuberculosis, the draft strategy sought to meet new challenges through the expansion of interventions by WHO and partners, particularly in support of access to high-quality and affordable second-line medicines, improved planning and use of resources, coordination of laboratory networks and the engagement of organizations and the private sector.

Tunisia had made great headway in controlling the disease and achieving specific goals but welcomed the points identified for ensuring the success of the draft strategy. His country would

continue to support the mechanisms for fighting tuberculosis, which should be used in the implementation of the Stop TB Partnership's global plan in order to achieve the desired targets.

Dr WANNA HANSHAOWORAKUL (Thailand) supported the draft strategy. To track progress towards the global targets, it was crucial to strengthen monitoring and evaluation mechanisms. Many countries were not currently able to collect data on certain indicators mentioned in the report, such as "percentage of affected families facing catastrophic costs due to tuberculosis". Even if an isolated system to monitor catastrophic costs were introduced, it would not be cost-effective unless it was integrated into a national health observatory. She favoured a greater emphasis on high-risk population groups, including prisoners and alcohol abusers, which would require innovative approaches and multisectoral partnerships. WHO and its development partners should provide technical support to make information systems faster and more accurate. She supported the draft resolution, but with the following proposed amendment to subparagraph 4(1): insertion of "including migrant populations" after the words "vulnerable communities".

Mr BAK (Slovakia) endorsed the draft strategy and targets, and urged WHO to intensify its work. Tuberculosis mainly affected the poorest and most vulnerable groups; its control would depend on effective prevention strategies, early diagnostic testing, treatment and screening of high-risk groups. Existing collaboration between low- and high-incidence countries and regions should be increased to reduce the risk of transmission, particularly in the context of increasing movement of people. He highlighted the importance of multisectoral action, including poverty-reduction activities, in tackling the social and economic determinants of the disease.

Dr GOUYA (Islamic Republic of Iran), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that tuberculosis control efforts should take account of the challenges faced in the Region, which had been exacerbated by chronic and complex emergencies, loss of human resources and destruction of infrastructure. Countries should adapt the draft strategy to national circumstances and update their national strategic plans accordingly. Those plans should include integration within the national health system, including primary health care services, and collaboration with other programmes to deal with the risk factors for tuberculosis, such as HIV infection, diabetes, tobacco smoking and undernutrition, as well as advocacy for the prioritization of tuberculosis on the health agenda in order to secure adequate resources. Legislation regarding case notification, social care and rational use of medicines for treating tuberculosis should be updated, and efforts to eliminate the disease altogether in a group of low- and medium-burden countries in the Region should be scaled up. He also pointed out the need to use new diagnostic methods to the full and intensify case-finding and treatment of multidrug-resistant and extensively drug-resistant tuberculosis.

Dr CHO Enhi (Republic of Korea) said that the elimination of tuberculosis would need public-private mix approaches, more tuberculosis specialists and allocation of resources where needed. Management of latent tuberculosis infection – by ensuring diagnosis of cases in vulnerable groups and by highlighting the need for regular check-ups – was also crucial to an effective response. Additional research and development were important, as were identifying and treating contacts of patients with tuberculosis. WHO should assume a leading role in projects to develop new tuberculosis vaccines.

Dr GONZÁLEZ FERNÁNDEZ (Cuba) said that universal health coverage and social protection were vital to achieving the ambitious targets of the draft strategy and ensuring that families did not face catastrophic costs due to tuberculosis. Although multistakeholder efforts would be required in that regard, governments in particular had a key role to play, which included ensuring that treatment was made available to all those who needed it. Implementation of the DOTS strategy would help to reduce rates of multidrug-resistant tuberculosis. The actions taken by his Government since 1962 had reduced tuberculosis incidence to 1 case per 100 000 population over the past 10 years, and various scenarios leading to its complete elimination had been drawn up.

Professor SEGOR (Kenya) reported that his country had made significant progress towards tuberculosis control since the implementation of the DOTS strategy, leading to a sustained annual reduction in incidence of 2% and achievement of the tuberculosis-related target of Millennium Development Goal 6 (Combat HIV/AIDS, malaria and other diseases). Treatment was provided free of charge for all tuberculosis patients. The provision of diagnostic facilities exceeded WHO's target. Improved surveillance was revealing an increasing number of multidrug-resistant cases, which were being treated in both the community and specialized facilities. Additional efforts were needed, not just in his country, to manage tuberculosis in children, including the supply of fixed-dose combination medicines in paediatric formulations. In order to consolidate the advances made in tuberculosis control and mitigate the effects of emerging challenges, equitable access to new tools and medical products for prevention, diagnosis and treatment should also be ensured.

Ms POLACH (Argentina) said that her country's tuberculosis control programme provided for free and universal access to first- and second-line medicines and promoted early detection. A national policy to administer BCG vaccine to newborn infants had reduced the incidence of invasive forms of tuberculosis. The post-2015 development agenda, which might include indicators related to tuberculosis, should be harmonized with the draft strategy. Given the varying levels of capacity in Member States, some countries would face challenges in meeting the targets set in the draft strategy, particularly in view of the current lack of appropriate vaccines, diagnostic products and treatments. The draft strategy should be adapted to national circumstances, and its indicators required further definition in order to provide a clearer understanding of the methods needed to implement them and enable countries to assess the availability of data to measure them.

Dr RIVERA (Bolivarian Republic of Venezuela) said that tuberculosis was closely linked with inequity and social exclusion; his Government had therefore made efforts to tackle the social determinants of the disease. Strategies to control tuberculosis must also incorporate principles such as free and universal access, equity, solidarity, social integration, cultural and linguistic appropriateness, multisectoral engagement, and social participation and responsibility. With regard to paragraph 61 of the draft strategy, he therefore suggested modifying the reference to universal health coverage by emphasizing that health was a human right and that governments should guarantee free, universal access to all necessary services.

Dr KESKİNKILIÇ (Turkey) observed that, although global incidence, prevalence and mortality rates were decreasing, the number of tuberculosis cases in the world was still high. As an essential component of actions to control the disease, his Government provided diagnostic and treatment services free of charge. His country was located at a junction of international migration routes and thus received registered and unregistered migrants as well as patients seeking treatment for drug-resistant tuberculosis. It was essential to strengthen cross-border activities in order to tackle tuberculosis in migrant populations. He strongly supported both the draft resolution and the draft strategy.

Dr CABELLO SARUBBI (Paraguay) said that the draft strategy and draft resolution should pay particular attention to intercultural issues in order to reach the most vulnerable populations, especially indigenous groups, which were greatly affected by social determinants such as poverty, undernutrition and poor access to health services. Welcoming the draft strategy's reference to the engagement of community and civil society organizations, she explained that her Government had implemented such initiatives to tackle persistent pockets of transmission. She underlined the need to incorporate the draft strategy into national policies and ensure the availability of adequate resources in order to enable all countries to meet the specified goals and objectives.

Dr VAAI (Samoa) expressed concern at the transmission of tuberculosis through migration and the increase in the incidence of multidrug-resistant forms of the disease. A multisectoral approach was vital in order to reduce the incidence of tuberculosis. Her Government had adopted strategies to

strengthen tuberculosis control, including building human resources capacity and increasing community engagement and awareness with regard to early diagnosis, enhanced case-finding and prevention.

Dr GOMEZ (Bahamas) asked the Secretariat to work towards ensuring that affordable medicines to prevent and control tuberculosis, particularly the multidrug-resistant forms of the disease, were made universally available. Further research was needed to identify new treatments. He welcomed the draft strategy and expressed support for the draft resolution.

Mr SEY (Gambia) said that, although the Millennium Development Goal target related to tuberculosis had been achieved, further action was needed to enable Member States in the African Region to meet the numerous challenges related to tuberculosis care and control. The first national prevalence survey conducted in Gambia in 2012 had revealed a prevalence of 128 cases per 100 000 population, but it was likely that a large proportion of cases still remained undetected. The survey had provided valuable country-specific epidemiological information that would be instrumental in adapting the strategy at the national level. He acknowledged continued support from partners, including WHO at national level, particularly help in conducting the survey and facilitating procurement of GeneXpert technology, which had significantly enhanced the case-detection rate.

Dr NICOLETTI (Italy) said that his country contributed to global tuberculosis control through bilateral cooperation and by supporting WHO's activities. Tuberculosis remained a major public health concern. As in other European countries, multidrug-resistant forms of the disease had appeared, posing a serious threat to the elimination of tuberculosis in Italy. His Government would be hosting a meeting co-organized by WHO and the European Respiratory Society in July 2014 to discuss approaches to eliminate tuberculosis in low-incidence countries. He supported the draft strategy.

Mr RUIZ MATUS (Mexico) said that, for the draft strategy to be successfully implemented, innovative technologies and proven methods must be provided in order to ensure access to diagnostic testing and treatment for all patients. Further support should be given to enable Member States to implement more robust strategies against multidrug-resistant and extensively drug-resistant tuberculosis. Integrated treatment should be provided for tuberculosis and comorbid conditions such as diabetes and HIV infection. To reduce the number of cases of drug-resistant tuberculosis, countries must introduce legislation to ensure that first- and second-line tuberculosis medicines were not sold in non-State pharmacies. There was an urgent need to increase global production capacity of quality-assured second-line medicines and paediatric formulations. He urged the Secretariat to provide specialist support to Member States with regard to management of medicines and harmonization of ad hoc national strategies, particularly those relating to drug-resistant tuberculosis, in order to treat the most vulnerable populations.

Dr TIN THITSAR LWIN (Myanmar), speaking on behalf of the Member States of the South-East Asia Region and acknowledging the elaboration of the draft strategy, said that, in order to sustain the achievements in tuberculosis control, particular attention should be paid to controlling drug-resistant tuberculosis. She requested WHO to provide accurate data, where possible in real time, on drug-resistant forms of the disease, and the regional offices to share the experiences of countries that had successfully controlled drug-resistant tuberculosis or established efficient sentinel surveillance systems. New tools would be needed to achieve the targets in the draft strategy, including better diagnostic testing, more effective, affordable and shorter courses of treatment and effective vaccines, especially for the multidrug-resistant and extensively drug-resistant forms of tuberculosis.

She expressed concern regarding the indicator related to the percentage of affected families facing catastrophic costs due to the disease and requested the inclusion of an indicator for drug-resistant tuberculosis and related activities in Table 2 of the draft strategy (paragraph 89). Specific actions might be required to tackle the issue of undetected tuberculosis in a cost-effective manner.

Referring to the challenges related to the detection of cases of tuberculosis in migrants, she asked the Secretariat to provide support to enable Member States to implement national migration health policies and strategies in coordination with other international organizations.

The Secretariat should provide support to enable Member States to strengthen information systems, enhance the capacity and capability of data collectors and handlers, and report effectively data on the indicators. It should also prepare to react promptly to untoward findings.

Dr TARAWNEH (Jordan) said that tuberculosis detection and treatment were provided free of charge in Jordan for nationals and others on its territory, including its refugee population of 1.5 million. A tuberculosis control programme aimed at stopping the spread of the disease by 2015, in accordance with the target in Millennium Development Goal 6, was also being implemented under the current national health strategy. The WHO case-detection and cure indicators had been achieved; indeed, Jordan's cure rate was about 5% higher than the WHO target of 85%. Jordan was committed to the principles enunciated in the draft strategy framework and would promote policies for the engagement of communities, civil society organizations and all public and private care providers.

Dr MUTAMBU (Zimbabwe) suggested that, in subparagraph 2(1) of the draft resolution, the words "in line with national priorities and specificities" should be added after the words "to adapt the strategy".

Dr KAMALIAH MOHAMAD NOH (Malaysia) called upon WHO to tackle the issue of the high cost of new diagnostic technologies, which constituted a significant barrier to effective action in many countries. As undocumented migrant workers were a continuing source of tuberculosis transmission, she pointed out the need to strengthen cross-border collaboration and consider new models of cost-sharing. She strongly supported the draft resolution.

Dr PAVIĆ ŠIMETIN (Croatia) said that multidrug-resistant tuberculosis constituted a significant health problem, especially in the European Region, where 10% of all cases involved extensively drug-resistant forms of the disease. Action should be taken to tackle cross-border transmission, extend intersectoral collaboration, strengthen surveillance systems, enhance research and develop new medicines and vaccines. Global efforts were hindered by the limited capability of some health systems, leading to inadequate health coverage and insufficient access to high-quality tuberculosis care, as well as inadequate social protection mechanisms. Member States relied on the Secretariat to support actively the development of a global investment plan by the Stop TB Partnership, as mentioned in the report, in order to deal with the substantial funding shortage. Endorsing the comprehensive draft strategy, she encouraged the Secretariat to provide support for Member States in reviewing, adopting and implementing national post-2015 tuberculosis strategies and targets based on the framework defined in the draft strategy.

Mr BOKENGE BOSUA (Democratic Republic of the Congo), referring to the increase in multidrug-resistant and extensively drug-resistant tuberculosis, suggested that a programme should be developed and implemented to strengthen cross-border collaboration, which would include national focal points in each country. The Democratic Republic of the Congo, with nine neighbouring countries, was particularly affected by cross-border transmission of the disease.

Ms GABBASOVA (Russian Federation) said that tuberculosis remained above all a medico-social problem. It was important to raise the awareness of the population, ensure prompt referral to specialists, promote adherence to treatment, improve laboratory diagnostics and introduce new rapid-testing techniques, particularly in respect of multidrug-resistant and extensively drug-resistant tuberculosis and coinfection with HIV. Her country had successfully overcome a national tuberculosis epidemic in 2005 and efforts undertaken since then had led to a significant reduction in mortality. She

expressed appreciation for the draft resolution, which should, however, stress cooperation with civil society, research, innovation, and interregional collaboration in the area of migrant health.

Dr SLAMET (Indonesia) said that, despite significant progress in his country, challenges remained, including HIV coinfection, multidrug-resistant forms of the disease and cases of tuberculosis among children. Recognizing that current global efforts to eliminate tuberculosis had proved insufficient, he endorsed the targets defined in the draft strategy. Indonesia had implemented a national plan to deal with tuberculosis, which already incorporated some of the elements and principles of the draft strategy. The draft resolution reflected the need for WHO and its partners to provide technical support for adaptation and implementation of the draft strategy.

Dr MASHAL (Afghanistan) said that tuberculosis constituted a major public health concern in his country, causing 11 000 deaths per year; 66% of cases occurred in women and girls. Nevertheless, the national tuberculosis prevention plan had steadily improved case notification, with 31 000 identified cases in 2013 and a treatment success rate of 91%. Expressing support for the draft strategy, he emphasized the importance of strengthening data quality and cross-border collaboration, as well as managing cases of tuberculosis among children, HIV coinfection and multidrug-resistant forms of the disease.

Ms IBRAHIM (Maldives) said that, although Maldives had achieved the global tuberculosis control targets for detection of 70% of new cases and cure of 85% of those cases, recent data showed an increase in incidence, with more cases of patients defaulting from treatment. Rapid growth in both international travel and migration increased the risk of imported tuberculosis globally and strengthened the case for coordinated efforts among Member States and with the Secretariat, including increased cross-border collaboration, to control the spread of the disease and meet the additional challenges of multidrug-resistant tuberculosis and HIV coinfection. Strict mechanisms were required to strengthen laboratories and develop quality-assured medicines. She strongly endorsed the draft global strategy.

Dr GRAND PIERRE (Haiti) welcomed WHO's efforts to increase the availability of diagnostic tests and second-line medicines. In Haiti, particular attention was focused on migrant populations and slum-dwellers. Although some progress had been made in integrating tuberculosis and HIV services, strengthened public-private partnerships were required to combat tuberculosis successfully.

Dr YOROU CHABI (Benin) expressed support for the draft strategy. Its implementation must involve the community and adopt a multisectoral approach with increased collaboration between Member States, as most patients lost to follow-up were migrants. Steps should also be taken to improve research and human resources training, as well as diagnostic laboratories, information systems and patient follow-up. The Secretariat should provide technical assistance to Member States as they implemented the strategy.

Dr Chang-Hsun CHEN (Chinese Taipei) endorsed the draft strategy and draft resolution. Efforts to control tuberculosis in Chinese Taipei had led to a 30% reduction in incidence between 2006 and 2013. Recognizing the difficulty of achieving the targets defined in the draft global strategy, he urged WHO to accelerate the development of new, accessible and affordable tools for diagnosis, treatment and prevention of tuberculosis. Chinese Taipei welcomed the opportunity to participate in international tuberculosis control efforts, and would incorporate the principles outlined in the draft global strategy into its own post-2015 tuberculosis prevention and control plan.

Dr DHAVAN (International Organization for Migration) welcomed the draft global strategy. Migration, as a social determinant of health, increased tuberculosis morbidity and mortality both of migrants and among communities along migration corridors and created challenges in terms of

prevention and care. The principles and three pillars contained in the draft strategy were a good basis for future action. However, future strategies for universal health coverage, social protection mechanisms and investment in tuberculosis care and prevention must all be sensitive to the needs of migrants; nor should the health of migrants be forgotten in the post-2015 development agenda. She looked forward to working with governments, civil society, WHO and other partners in the areas of technical guidance, policy advocacy and providing practical solutions in the implementation of the draft global strategy.

Ms KUSYNOVÁ (International Pharmaceutical Federation), speaking at the invitation of the CHAIRMAN, welcomed the draft global strategy and targets and recalled that, in 2011, WHO and the Federation, jointly recognizing the importance of involving pharmacists in tuberculosis care and control, had drawn up a blueprint for collaboration between national tuberculosis programmes and national pharmacy associations to combat tuberculosis and multidrug-resistant tuberculosis. Several national policies had been developed, including a project in the Philippines to improve access to treatment (under the DOTS strategy) through pharmacies. She expressed the renewed commitment of pharmacists worldwide to the draft global strategy and its adoption and adaptation at national level.

Ms TISILE (MSF International), speaking at the invitation of the CHAIRMAN, described how her own experience of contracting multidrug-resistant tuberculosis and the serious side-effects of the treatment had prompted her to write the “Test Me, Treat Me” manifesto, which had already been endorsed by 50 000 people worldwide. The manifesto contained three demands: universal access to fast and accurate diagnosis and to locally available treatment; more effective, tolerable, affordable and shorter treatment regimens; and increased funding for diagnosis and treatment of drug-resistant tuberculosis, including research into new, affordable treatments and other innovations. The targets set out in the draft strategy, though welcome, were not enough. There must also be action for change.

Mr NISPEROS (Medicus Mundi International – International Organisation for Cooperation in Health Care), speaking at the invitation of the CHAIRMAN, expressed concern that, in its current form, the draft global strategy would simply repeat the shortcomings of previous strategies because of the limitations imposed by its clinical framework, reliance on diagnostics, medicines, research and innovation, and focus on cure and treatment. The persistence of the disease despite earlier efforts was linked to poverty and marginalization and a failure to deal with the social determinants of health. The multisectoral approach of the draft global strategy provided an opportunity for innovation, as long as emphasis was placed on integration rather than on vertical programmes and any new plan was embedded in a primary health care approach, operating entirely in the public sector and underpinned by intersectoral and participatory processes. Governments were expected to play their part in ending the tuberculosis epidemic, but the pharmaceutical industry should also be held more accountable. Moreover, policies and strategies should explicitly address issues of fundamental human rights, ethics and equity.

Dr NAKATANI (Assistant Director-General), thanking speakers for their constructive comments, noted their broad support for both the draft strategy and the draft resolution. Member States clearly attached high priority to the following issues: HIV-associated tuberculosis; multidrug-resistant tuberculosis, including diagnosis and treatment; tuberculosis among vulnerable populations, such as migrants and children; and health system integration. Those elements should be incorporated into basic tuberculosis care services such as the DOTS strategy.

Replying to points raised by Member States, he affirmed the importance of participation from the private sector. Partnerships had also been established with, for example, the International Drug Purchase Facility (UNITAID) and the Global Fund to Fight AIDS, Tuberculosis and Malaria, which had led to a reduction in the price of commodities. The guidelines developed by WHO were a useful tool in that regard. In recent years, new diagnostics and medicines had become available, thereby underlining the importance of partnerships. The Director-General was committed to ensuring access to

medicines and medical products, as specified in the Twelfth General Programme of Work, 2014–2019. With regard to monitoring indicators and systems, he acknowledged the need for further work. Referring to delegates' comments regarding social protection, he stressed that tuberculosis was directly related to social determinants, such as poverty, and that a cross-cutting, whole-of-government approach was therefore necessary. He confirmed that a glossary of terms used in the draft strategy would be created.

Rather than opening discussion on the draft strategy, he noted that the Secretariat would respond to the concerns in a guidance document that would be prepared on adapting and implementing the strategy at the national level, within the framework of the draft resolution.

The CHAIRMAN invited the Secretary of the Committee to read out the proposed amendments to the draft resolution contained in resolution EB134.R4.

Dr ARMSTRONG (Secretary) said that the delegate of Zimbabwe had proposed an amendment to subparagraph 2(1), which would now read: "to adapt the strategy in line with national priorities and specificities". In subparagraph 4(1), the delegate of Thailand had proposed the addition of the words "including migrant populations", so that the subparagraph would now read: "to provide guidance to Member States on how to adapt and operationalize the strategy, including the promotion of cross-border collaboration to address the needs of vulnerable communities, including migrant populations, and the threats posed by drug resistance".

The CHAIRMAN said that, in the absence of any objections, she took it that the Committee wished to approve the draft resolution contained in resolution EB134.R4, as amended.

The draft resolution, as amended, was approved.¹

The meeting rose at 18:30.

¹ Transmitted to the Health Assembly in the Committee's first report and adopted as resolution WHA67.1.

SECOND MEETING

Tuesday, 20 May 2014, at 09:15

Chairman: Dr P. RENDI-WAGNER (Austria)

later: Dr J.A. VILLAVICENCIO (Guatemala)

1. FIRST REPORT OF COMMITTEE A (Document A67/62)

Dr MBUGUA (Kenya), Rapporteur, read out the draft first report of Committee A.

The report was adopted.¹

2. WHO REFORM: Item 11 of the Agenda

Framework of engagement with non-State actors: Item 11.3 of the Agenda (Documents A67/6 and A67/54)

Dr BAYE LUKONG (Cameroon), speaking in her capacity as Vice-Chairman of the Programme, Budget and Administration Committee of the Executive Board, reported on the outcome of the Committee's deliberations on the draft framework of engagement with non-State actors at its twentieth meeting. It had been proposed that a working group be established. The Committee, on behalf of the Executive Board, had recommended that the Sixty-seventh World Health Assembly note the report contained in document A67/6.

Dr GOUDOU COFFIE (Côte d'Ivoire) expressed strong support for the draft framework contained in document A67/6, which provided fresh guidance for cooperation with the private sector and took account of the recommendations and observations made by various Member States during the drafting process.

Dr LAHTINEN (Finland), speaking on behalf of the Member States of the European Region, said that, in a world that was very different from the one in which WHO had been established more than 60 years earlier, civil society, philanthropic foundations, academic institutions and the private sector all currently played a role, for better or worse, in global health. In that new context, WHO's continued global health leadership depended on ensuring that it had adequate space for dialogue with a multitude of players. The proposed principles and policies for engagement with non-State actors fully respected existing rules for intergovernmental decision-making at WHO. It was essential that all WHO's engagements with non-State actors be directed to achieving public health benefits, while protecting WHO from undue influence. Application of the principles and policies would facilitate certain processes in the coming months, for example, the work related to the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases and the preparations for the Second International Conference on Nutrition. He supported the

¹ See page 346.

adoption of those principles and policies by the Health Assembly and their review by a future Health Assembly.

Dr WARISA PANICHKRIANGKRAI (Thailand) expressed support for the draft framework with the five types of non-State actors it identified. Although each type was clearly distinguished, past experience had shown difficulties in making those distinctions. The increasing importance of non-State actors had led to their being recognized as equal partners alongside States in many global health mechanisms, including the Board of the Global Fund to Fight AIDS, Tuberculosis and Malaria, as well as the boards of several newly established independent public health agencies in Thailand. For the sake of transparency, therefore, the time had come to involve non-State actors in the governing structure of WHO, on an equal footing with Member States. The potential for conflicts of interest and other risks would have to be managed and careful consideration would have to be given to the number and term of membership of non-State actors and the type of engagement with them, as well as the way in which they were selected. Also, WHO should draw up a clear exclusion list of products that were harmful to human health. An appropriate number of non-State actors could play an effective but balanced role in the governing structure, with Member States remaining the main players. The mechanisms and processes leading to the adoption of a resolution on the subject should be redesigned and based on the principle of consensus rather than majority voting.

Dr SHAHANIZAN MOHD ZIN (Malaysia), noting that the draft framework reflected the many comments made by Member States during the informal consultations held in March 2014, strongly recommended its adoption, as it was long overdue and would have a direct impact on the work of WHO. Multisectoral action was an important strategy, particularly for the prevention and control of noncommunicable diseases, and the draft framework would provide Member States with a strong basis for creating and strengthening their own framework of engagement with nongovernmental organizations and the private sector. The framework could be fine-tuned on the basis of experience.

Dr BUGTI (Pakistan), emphasizing a multisectoral approach to public health, said that the draft framework was still lacking in detail and clarity, especially with regard to the policy on conflicts of interest. Adequate measures and mechanisms were required to ensure that both individual and institutional conflicts of interest were avoided or appropriately managed. Such a policy would identify actors with which WHO would categorically refuse to engage. The draft framework therefore required further deliberation before it could be finalized.

Mr ROSALES LOZADA (Plurinational State of Bolivia) endorsed the distinction made in the draft framework between nongovernmental organizations, private sector entities, philanthropic foundations and academic institutions, and the approach taken of establishing specific draft policies and operational procedures to govern WHO's relationship with such actors, and of setting clear boundaries for engagement with them. He proposed the establishment of a working group to discuss changes to the text to make it clearer and reduce the risk of undue influence.

In the draft overarching framework for engagement with non-State actors, he proposed to delete "directly" in paragraph 6(c); to add a sentence at the end of paragraph 8, by analogy with paragraph 11, reading: "If a nongovernmental organization is clearly influenced by a private sector entity, it is considered as a private sector entity"; to insert in paragraph 11 a sentence reading: "Foundations that have interests in commercial entities or that may have conflicts of interest with the principles of the Organization and this overarching framework shall also be considered private sector entities"; to clarify the meaning of "level" and "modalities" in paragraph 34; and to delete "funding" in paragraph 37, as funding was a key criterion for identifying the different types of non-State actors.

In the draft WHO policy and operational procedures on engagement with nongovernmental organizations, he proposed to add a sentence to paragraph 7 reading: "In this context, any nongovernmental organizations that make contributions to WHO shall indicate the origin of those

resources”, and to amend paragraph 14, as staff secondments from nongovernmental organizations to WHO were not acceptable.

In the draft WHO policy and operational procedures on engagement with private sector entities, he proposed to add the words “or for the collection and processing of information” to subparagraph 12(a), in order to ensure that research remained unbiased (indeed, private sector funds should not be attributed to any specific activity but rather to the Organization’s regular budget); to delete “in principle” in paragraph 19; and to clarify the wording of paragraph 27 to close the loophole allowing private sector entities to finance the participation of WHO staff in private activities.

All resolutions, mechanisms and working groups should be subject to the overarching framework; in its absence, therefore, or until such time as the text had been adopted, no new mechanism or working group should be approved that involved WHO’s engagement with non-State actors.

The CHAIRMAN asked the delegate of the Plurinational State of Bolivia to submit his proposals in writing.

Dr AL-TAAE (Iraq) said that engagement with non-State actors was a prerequisite for achievement of Millennium Development Goal 8 (Develop a global partnership for development). Cooperation between international organizations in general and WHO specifically, on the one hand, and civil society institutions and other private health sector bodies, on the other, was essential for raising the profile of public health issues, especially as increased investment in primary health care activities was generated by intersectoral collaboration and community participation. That was a central element of WHO reform.

Mr JONES (Canada), noting that Member States and the Secretariat could not tackle current global health challenges on their own, strongly supported the Organization’s engagement with a broad range of non-State actors in order to expand its access to key public health expertise, knowledge and resources. WHO must equip itself with the tools needed effectively to engage with non-State actors and manage those engagements, and he therefore appreciated the significant progress made in developing and refining the framework of engagement with non-State actors since the 134th session of the Executive Board: the draft framework had been expanded to apply to all non-State actors, with specific rules and procedures for different groups of such actors. It was transparent and inclusive, and had been structured in such a way as to mitigate the risk of real, perceived or potential conflicts of interest inherent in WHO’s engagement with non-State actors. The draft framework should be adopted by the current Health Assembly and evaluated by a subsequent Health Assembly.

Ms BLACKWOOD (United States of America) expressed support for the adoption of the draft framework by the current Health Assembly, as it reflected the various inputs provided at the second consultative meeting in March 2014 and provided a coherent mechanism and specific policies for engagement with four identified types of non-State actors. A new basis for engagement with non-State actors would facilitate Member States’ efforts to ensure proper governance in an accountable framework that protected WHO’s normative work. Those dynamic and varied actors needed to have proper rules of engagement in order to form public health partnerships and contribute to multi-stakeholder and multisectoral action. WHO’s engagement should be guided by transparent rules and a solid framework that consolidated its leadership role in global health.

Dr TSESHKOVSKY (Russian Federation) acknowledged the consultative process and the preparation of the document setting out the possibilities and boundaries for engagement in five categories of interaction with four different groups of non-State actors. Such actors played an important and growing role in aspects of socioeconomic development relating to human health and in the provision of medical services. In order to retain its leading role in global health care and meet its commitments regarding coordination and optimum use of resources, WHO must engage in an open

dialogue with non-State actors. In developing the framework of engagement, consideration had been given to the need to create a transparent and robust framework to identify risks, including those related to acceptance of financial contributions and other resources, and instruments to protect WHO's reputation. The substantive part of the document was well developed, based on well-known provisions of the Constitution and the Organization's other basic documents, as well as previously agreed principles governing relations between WHO and nongovernmental organizations, including private sector entities. He considered that the draft framework with its policies and operational procedures was sufficiently reliable for use in support of WHO's mission.

Dr TANAKA (Japan) noted that the involvement of players other than WHO in the global health arena made it essential to build appropriate cooperative relations with non-State actors. The issue was sensitive and needed to be handled with extreme caution. For example, dealings with a specific private sector company must not in any way affect WHO's normative function, and potential conflicts of interest must be monitored; the mere suspicion of improper relationships with a non-State actor would considerably impair the Organization's ability to perform that function. He favoured proactive collaboration with non-State actors, including nongovernmental organizations, but such cooperation needed full transparency and strict compliance with WHO's rules and regulations, and was therefore contingent on complete disclosure of information and robust measures for dealing with non-compliance.

Mr COTTERELL (Australia) said that the draft framework filled a major gap in WHO's reform programme and its application should not be delayed. Although it could be improved in some areas, such as competitive neutrality, it provided a good basis in its current form for implementation over the coming two years, with a review at the end of that period. He urged Member States not to open the text for discussion at the current Health Assembly, but to endorse it for implementation with a view to learning practical lessons from its implementation over the coming two years.

Ms MATSOSO (South Africa) agreed that the draft framework should not be reopened for further discussion at that point, noting that Member States' responsiveness throughout the informal consultations had enabled them to reach a consensus on the text. Because of the changed public health landscape, measures were needed in order to manage conflicts of interest. Non-State actors were not a homogeneous group, and rules were needed in order to govern WHO's engagement with them.

Dr MUTAMBU (Zimbabwe) asked that further consultations be held before the draft framework was finalized. WHO had long-standing rules that already governed interaction with non-State actors, and the draft framework needed to be clearer with regard to issues of finance and secondment of staff from non-State actors. It was also necessary to guard against conflicts of interest and ensure that non-State actors contributed to the fulfilment of WHO's mandate.

Dr MPOKE (Kenya) expressed support for the draft framework as part of WHO reform. The Organization's engagement with non-State actors could bring important benefits for global public health and WHO itself, and he therefore also supported the four separate policies and operational procedures contained in document A67/6. The engagement process must be transparent and constructive, be characterized by mutual respect, and must protect and preserve WHO's integrity and reputation. Due diligence was essential to protect WHO from individual or institutional conflicts of interest. With regard to the draft WHO policy and operational procedure on engagement with private sector entities, caution must be exercised about engagement with non-State actors that did not promote public health, such as delegations representing the tobacco, food and alcohol industries, and with regional economic integration organizations fronting a trade agenda that might erode, undermine, jeopardize or ultimately circumvent public health policies.

Dr LATIF (Afghanistan) expressed concern that the draft framework did not adequately deal with the issue of conflicts of interest, inasmuch as it would allow business associations and venture philanthropists to enter into official relations with WHO. It would also allow the corporate sector to provide WHO with financial and human resources, threatening the Organization's integrity, independence and credibility.

Mrs TYSON (United Kingdom of Great Britain and Northern Ireland) applauded the expansion of the draft framework to cover all varieties of non-State actors under a general set of principles. She strongly urged Member States to adopt the draft framework as it stood and to review it in due course to iron out any remaining imperfections. Member States should be guided by the principles of realism, caution and transparency in their pursuit of essential public health aims.

Mr MISHRA (India) welcomed the participation of non-State actors of all kinds in the endeavour to advance public health. However, the draft framework should be clearer about roles and leadership and, in particular, with reference to conflicts of interest, funding and resource provision in general. Although the draft framework stipulated that WHO would not engage with industries making products that directly harmed human health, care would have to be taken to guard against indirect funding from such industries. Further deliberations were therefore required before the draft framework could be finalized.

Mrs NAARENDORP (Suriname), speaking on behalf of the Union of South American Nations (UNASUR), said that, although its members were committed to the reform process and considered it essential to define rules for engagement with non-State actors, they nevertheless continued to have serious doubts and concerns about the draft framework. They agreed that the main objective of WHO's cooperation with non-State actors was the fulfilment of the Organization's mandate, and noted that many of their suggestions had been incorporated into the draft framework, notably the identification of separate categories of interaction with the different types of non-State actors and the need to avoid conflicts of interest. WHO already had general rules governing its engagement with non-State actors, but, as the Pandemic Influenza Preparedness experience had shown, there was room for improvement. The text of the draft framework had been significantly improved in the areas of evaluation procedures and transparency criteria, but the consultations held to date had revealed the need for further discussion, for which the Health Assembly provided a favourable setting. Points that required clarification as a matter of priority included contributions and acceptance of resources from non-State actors, risk assessment, the criteria for identifying conflicts of interest (including type of actor), and the rules and criteria for staff secondments and staff relations with the private sector.

Dr DANG VIET HUNG (Viet Nam) said that WHO had to engage with non-State actors given the growing number of players in global health governance and the significant contribution such actors made to WHO's work and to the health of populations. However, such engagement also carried potential risks, such as undue or improper influence on the Organization's work, negative impact on its reputation and credibility, or misuse of collaboration with WHO for non-State actors' own benefit. A circumspect approach should be taken to further development of the draft framework with the aim of promoting public health without losing sight of the intergovernmental nature of WHO.

Ms HERNÁNDEZ NARVÁEZ (Mexico) acknowledged the importance of the draft framework for strengthening the rules governing engagement with non-State actors; the definitions it contained made it easier to make practical use of the text. The revised rationale, principles and boundaries of the draft overarching framework should serve to prevent misinterpretations in WHO's collaborative relations with nongovernmental organizations and private sector entities. The principles should underpin any relations with non-State entities and should be cautiously construed. In view of the concerns expressed by many Member States, she proposed that an open-ended working group should be established to expedite finalization of the draft framework.

Dr MYINT HTWE (Myanmar) fully supported the draft framework in principle, especially from the point of view of promoting public health, but asked the Secretariat, when finalizing the text, to take full account of the concerns and suggestions of the delegate of Japan and other speakers. The draft framework had many serious, long-term implications for WHO, some positive, some negative.

Dr BLOOMFIELD (New Zealand) agreed with previous speakers that the draft framework should be adopted by the current Health Assembly. The framework was not a stand-alone document; it must be considered within the context of WHO's Constitution, rules and regulations, and existing policies and processes for managing conflicts of interest. It provided an important platform for advancing many of WHO's activities and in particular for tackling some of the key challenges in the prevention and control of noncommunicable diseases. Member States must remain involved in the implementation, evaluation and review of the framework.

Ms LANTERI (Monaco) said that, as the draft framework was sufficiently detailed and comprehensive to be implemented, there was no reason to delay the conclusion or implementation of other processes under way at WHO with regard, for example, to noncommunicable diseases and the Second International Conference on Nutrition. The draft framework should be adopted by the current Health Assembly and reviewed within two years.

Ms POLACH (Argentina), said that, although she agreed with the need to establish a general framework for interactions with non-State actors, to distinguish between various groups of actors and to implement separate policies and operational procedures for each group, further work was needed on the classification of actors in terms of sources of funding and other criteria. For that reason, she considered the current draft of the framework of engagement to be a preliminary version. Further consideration also had to be given to the types of interaction, in particular with regard to the resources and risks that engagement implied. For oversight of engagement (document A67/6, paragraphs 64–66) to analyse conflicts of interest, a standing ethics committee should be established, with the participation of Member States. The participation of non-State actors in informal meetings or consultations should be reviewed on a case-by-case basis. It was also important that Member States have timely access to relevant documents. She agreed with other speakers that all outstanding matters should be dealt with in a drafting group.

Mr DIKMEN (Turkey) said that the draft framework was based on an approach in which the potential benefits outweighed the risks, and was expected to help WHO better manage its interaction with non-State actors. It regulated the Organization's engagement with different types of non-State actor and had to be evaluated in the light of potential public health benefits and risks. The global health sector had become a competitive arena with many different players. In that context, WHO should focus on and strengthen its efforts towards the attainment by all peoples of the highest possible level of health. As an integral part of WHO reform, management of WHO's interaction with non-State actors was an important step towards implementing the Programme budget, through multisectoral and multistakeholder activities. Such interaction had to be managed in a way that prioritized WHO's goals, not financial contributions. The due diligence, risk management and risk mitigation components of the draft framework were therefore of utmost importance.

Mr SVERSUT (Brazil) said that the draft framework for engagement could not be adopted in its current form. The entire membership should further discuss and review the whole of the text in order to reach consensus in an open and transparent manner. A robust and agreed framework for interaction with non-State actors would help to strengthen WHO's role in the complex global health landscape.

He welcomed the structure of the draft overarching framework for engagement and the policies and operational procedures for each of the four groups of non-State actors. That differentiation would allow the Organization to modulate its engagement according to the type of interaction and actor. The Pandemic Influenza Preparedness experience could usefully inform those discussions, in a process that

had to respect WHO's intergovernmental nature. Clear and well-defined rules were the basis for protecting WHO from undue influence, risks and conflicts of interest, and should be systematically applied to all non-State actors and forms of interaction. The policy on conflicts of interest had to be clarified; the secondment of personnel from the private sector to WHO represented a direct conflict of interest and was therefore unacceptable.

Ms ZHANG Yang (China) said that WHO's engagement with non-State actors had to be strictly limited to nongovernmental organizations, business associations, philanthropic foundations and academic institutions, and the scope of such engagement should be limited to participation, resources, evidence, advocacy and technical cooperation. If international business associations, as described in paragraph 10 of the draft overarching framework, were categorized as being in the private sector, they should be included in paragraph 9 on private sector entities and not figure in a stand-alone paragraph. She expressed support for the establishment of the Committee on Non-State Actors to deal with issues relevant to engagement with such actors, but the Committee's composition and organization merited further discussion. She endorsed the procedure for admitting and reviewing organizations in official relations, which, if it was not transparent, would undermine WHO's reputation and the cause of global health. WHO's engagement with non-State actors therefore had to be subject to strict risk management and control, and verification, evaluation and risk management had to be open and transparent; a cautious and prudent approach was called for. At the twentieth meeting of the Programme, Budget and Administration Committee, many delegates had said that they had not had enough time to analyse the draft framework because of its late posting; it was therefore premature to suggest that the draft framework be adopted by the current Health Assembly.

Ms KEKEMPANOU (Greece), speaking on behalf of the European Union and its Member States, said that interaction with non-State actors was a prerequisite for strengthening WHO's contribution to global health while maintaining the Organization's integrity and objectivity. The draft text provided a good policy framework that could be applied with immediate effect and should be adopted forthwith. Its operation could be reviewed in two years' time.

Mrs IBEKWE (Nigeria) expressed support for the draft framework, which provided a sound basis for implementation, and agreed that a review would be necessary in two years' time. However, in order to ensure transparency and sustainability, the provisions on non-compliance should be considered more critically and strengthened.

Mr KUEMMEL (Germany) noted that the strengthening of WHO's position in the global health architecture relative to other major global health entities was a key objective of WHO reform. WHO could only fulfil its leadership role and mandate under the Constitution if it were able to engage proactively with, coordinate and steer all global health actors, including those that were not Member States. The importance of non-State actors' role in the WHO setting was demonstrated by the fact that four of them ranked among the Organization's top 10 donors. WHO would not lose its influence on global health by adopting a robust framework for its engagement with non-State actors; rather, the framework was an essential means of strengthening WHO's leadership and coordinating role among all global health actors, including both Member States and non-State actors. WHO's engagement with non-State actors had been discussed extensively since the start of the reform process four years earlier. The Member States' constructive work during those four years should be rewarded by the adoption of the framework by the Health Assembly.

Dr VALLEJO (Ecuador) agreed with previous speakers on the need for a prudent approach to such an important subject and for a working group to carry out a rapid final review of the draft framework. WHO was one of the few remaining Member State-driven organizations and States must continue to bear primary responsibility for the health of their citizens. Contributions from nongovernmental sources should be scrutinized carefully.

Ms PENEVEYRE (Switzerland) noted that the new version of the draft framework reflected the outcome of the consultations held in March 2014 and struck a good balance between the benefits and risks of engagement with non-State actors. Implementation of the principles adopted would constitute a major challenge and would have to be ensured at all three levels of the Organization in order to guarantee WHO's independence. The draft framework should be adopted by the current Health Assembly.

Dr CHO Enhi (Republic of Korea) agreed in principle that WHO's engagement with non-State actors should be enhanced, but said that a more specific and credible vetting process was needed to enable WHO to take decisions on engagement. Once such decisions were taken, the non-State actors concerned should provide Member States with information on their activities, status and contributions to WHO, and the Member States should review that information on a regular basis with a view to deciding whether to disengage with certain non-State actors.

Ms SAMIYA (Maldives) expressed the hope that the proposed working group would make good progress towards finalizing the draft framework. Interaction with non-State actors should be overseen by an Executive Board committee on non-State actors, in accordance with the terms of reference proposed in the draft framework for such a committee. She commended the guidelines for official relations set out in the draft framework, including the initiative to maintain an up-to-date register of non-State actors and the process by which the Secretariat would review official relations, particularly from the point of view of potential risks. It was important, when engaging with non-State actors, to carry out independent evaluations of the engagement processes, to build on existing mechanisms and to work for continuous improvement in WHO's interaction with non-State actors.

Ms BILINSKA (International Alliance of Patients' Organizations), speaking at the invitation of the CHAIRMAN and welcoming WHO's efforts to strengthen its engagement with non-State actors, acknowledged the vital support provided by non-State actors for the Organization's work and their key role in furthering its mandate. The draft framework should give priority to enabling WHO to engage with a broad range of stakeholders and have at its core an understanding of the benefits that a genuinely collaborative relationship with nongovernmental organizations could bring to both parties. In order to ensure the legitimacy and credibility of the non-State actors with which WHO engaged, the framework should incorporate consistent and appropriate engagement criteria requiring information on non-State actors' aims, who they represented and how they were governed. All eligible non-State actors should be able to participate in WHO's activities equally and without prejudice.

Dr LHOTSKA (International Baby Food Action Network), speaking at the invitation of the CHAIRMAN, said that the draft framework fell short of WHO's mandate to strengthen dialogue and cooperation with other stakeholders while taking into account the importance of managing conflicts of interest. In its current form, the framework would allow transnational corporations and philanthropic foundations to increase their influence in various ways. Admitting business associations and venture philanthropists into official relations would not reverse the trend of accrediting actors whose primary aims were not in conformity with the spirit of WHO's Constitution. In the name of inclusiveness, it opened up other channels for corporate and donor influence, including staff secondment, pro-bono work, participation in meetings and support to policy-making. The approach to risk assessment gave the misleading impression that institutional conflicts of interest referred to conflicts between WHO's work and the vested interests of non-State actors, whereas in fact they concerned the risk of WHO's constitutional mandate and functions being unduly influenced by its own secondary interests, for example its efforts to secure funding.

Dr REED (Stichting Health Action International), speaking at the invitation of the CHAIRMAN, said the relationship between his organization and WHO was exemplary, based on shared values and with examples of successful collaboration on issues such as pharmaceutical

promotion and rational use of medicines. However, the blurring of crucial distinctions between civil society and the private sector in the draft framework was problematic as they could not be considered to share the same value-based primary interests; private sector entities could not be subsumed in the proposed framework under the guise of non-State actors. The proposed approach to conflicts of interest lacked rigour and could lead to corporate capture of the global public health arena. He called on WHO to convene a series of high-level seminars and workshops on conflict of interest and democratic governance, to be attended by academics and public interest groups with experience in corporate accountability, with a view to providing input to WHO policy in that area.

Ms LAWRENCE-SAMUEL (Corporate Accountability International), speaking at the invitation of the CHAIRMAN, urged Member States to strengthen the draft framework with provisions recognizing that interaction with certain industries, which were driven by commercial interests and generated contemporary health problems, presented an inherent and irreconcilable conflict of interest with public health. The framework of engagement with non-State actors should thus preclude engagement with the food, beverage, alcohol and pharmaceutical industries, given the harm caused to health by specific policies and products. The framework should also include the safeguards outlined in the WHO Framework Convention on Tobacco Control for engagement with private sector entities and it should prohibit all kinds of contributions from private sector entities and their affiliates, whose activities ran counter to the work of WHO.

Mr LEGGE (Medicus Mundi International – International Organisation for Cooperation in Health Care), speaking at the invitation of the CHAIRMAN, considered that the recognition of business associations as private sector entities in the draft framework of engagement represented a step forward. However, the new policy on improper influence and conflict of interest might not be sufficient to curb the influence of private sector interests over the functioning of WHO, as it focused on complex, bureaucratic procedures rather than the structural causes of improper influence. In recent cases involving real or perceived improper influence, including the Pandemic Influenza Preparedness (PIP) crisis and management of pandemic influenza (H1N1) 2009, conflicts of interest had been self-evident but the immediate contingencies had been seen as more pressing and protection of WHO's principles had not been prioritized. In cases where managers competed for visibility and donor attention, the risks of improper influence were regarded as a low priority. He urged Member States to accept their responsibilities regarding WHO, increase their assessed contributions and curb the dominance of the donors.

Mr OTTIGLIO (International Federation of Pharmaceutical Manufacturers and Associations), speaking at the invitation of the CHAIRMAN, welcomed the draft framework, which would enable WHO to fulfil its leadership role in global health. He emphasized his organization's respect for the supremacy of WHO's Member States in normative work and the need to design a transparent set of rules that were applicable to all. Collaborative approaches were fundamental to much of the work on global health challenges. It was important that the practices of risk management and due diligence be enforced equally among all non-State actors. Accountability should be reinforced as a key metric for assessing tangible contributions from non-State actors to the achievement of WHO's objectives. Differentiation should not mean discrimination, and the rules governing categories of resources, advocacy and participation in advisory groups should be harmonized to enable WHO to maximize its interaction with the global health community.

Dr SMITH (Executive Director, Office of the Director-General) thanked delegates for their comments and expressed appreciation to the Special Envoy on WHO's engagement with non-State actors, Professor Thomas Zeltner, for his work on the subject. He looked forward to concluding the framework with the support of Member States.

The DIRECTOR-GENERAL thanked all speakers for their statements and their consensus on the important role of WHO as the guiding authority on global health and also expressed particular thanks to Professor Thomas Zeltner. She noted that the draft framework for engagement with non-State actors was considered an improvement that reflected a diverse range of views. Her role was to support Member States in determining their positions. Therefore, although some Member States were ready to adopt the document under discussion, she would facilitate the setting up of a working group to discuss the framework, as dialogue was paramount and Member States were the shareholders of WHO. In order for the Organization to move forward and fulfil its mandate, action and proposals from global partners needed to be relevant. The supremacy of WHO's Members in decision-making would not be compromised and the diversity of negative and positive experiences from all Member States should serve as lessons learnt. She would welcome concrete proposals regarding the management of conflicts of interest.

The CHAIRMAN proposed that a drafting group be set up to discuss the framework further.

It was so agreed.

(For continuation of the discussion, see the summary record of the tenth meeting, section 1.)

Progress report on reform implementation: Item 11.1 of the Agenda (Documents A67/4, A67/54 and A67/INF.1)

Dr BAYE LUKONG (Cameroon), speaking in her capacity as Vice-Chairman of the Programme, Budget and Administration Committee of the Executive Board, summarized the Committee's report on the item (document A67/54, paragraphs 2–6). The Committee, on behalf of the Executive Board, had recommended that the Sixty-seventh World Health Assembly note the progress report (document A67/4).

Dr AMMAR (Lebanon), speaking on behalf of the Member States of the Eastern Mediterranean Region, noted that the Health Assembly's adoption of the Programme budget 2014–2015 in its entirety had facilitated Member States' oversight of all the Organization's resources and set the stage for improving the predictability, alignment, flexibility and transparency of WHO's financing. However, the programme budget should also be used as a tool to monitor accountability at all three levels of the Organization. Country offices, which held the key to the Organization's effectiveness and reputation, seemed untouched by WHO reform. They were not allocated sufficient resources and should be more accountable; for example, no effective mechanism was in place to measure the performance of WHO representatives. As had been noted in the independent evaluation, the absence of change-management activities directly targeting Member States must be remedied for WHO reform to have an impact at country level. He strongly supported the implementation of the evaluation team's recommendations outlined in document A67/4 (paragraph 32). It was essential, at the current stage of the reform process, to institutionalize change at all levels of the Organization.

Dr AL-TAAE (Iraq) called on WHO to develop a country-specific biennial work plan focusing on priority areas and investment of resources. It was also important to establish cost-sharing approaches involving WHO and individual countries, taking into account epidemiology and demography. Work plans should be developed in cooperation with the United Nations Development Assessment Framework to ensure adequate investment of resources through other organizations of the United Nations system.

Dr KAMWI (Namibia), speaking on behalf of the Member States of the African Region, welcomed the report in document A67/4 but expressed concern at the varying rates of progress towards completing the reform agenda. Progress was slowest in the area of governance, which also

affected programmatic and management reform. Consensus should be sought in respect of governance and engagement with non-State actors, and the WHO country offices should be central to the reform effort. The Organization would remain relevant if it delivered timely, high-quality support to countries. The country offices should therefore be given the necessary structure and resources to fulfil their role, instead of being trimmed at the expense of a top-heavy headquarters. WHO reforms at country level should be accelerated.

Noting with concern the under-representation of African experts in leadership, managerial and technical positions at WHO headquarters, he said that reform efforts should focus on rotation, mobility and diversity. With regard to management reform, he welcomed the fact that the revised human resources strategy was to be a reform priority for 2015. He exhorted the Secretariat to accelerate and strengthen implementation of the reform, ensure that the new reform results framework was consistent with the initial reform goals, and facilitate faster transition from policy analysis to implementation.

Dr TSESHKOVSKY (Russian Federation) noted with satisfaction the systematic approach to the evaluation of progress in reform. Evaluation of the degree of implementation of programmatic reform depended on numerous factors, such as transparency in the organization of internal networks, coordination of contributions across the three levels of the Organization and financial commitments under the Programme budget 2014–2015. Notable progress had been made in governance reform with better communication between the global and regional levels and harmonizing governing bodies' procedures. However, despite the recognition by Member States of the need for urgent action, no mechanism had yet been set up to enhance the effectiveness of governance decisions, such as the strategic distribution of resources and the setting of manageable agendas – their current size led to violation of the governing bodies' rules of procedure. Furthermore, the Secretariat did not always manage to produce documents in a timely manner, which hindered the effectiveness of the work of the governing bodies. A set of measures regarding governance should be implemented at the country level, to ensure optimal staffing levels and fair resource distribution. The new web portal promised to provide information on financing and to serve as a tool for accountability and reporting on results. For those functions it would need to be backed by a comprehensive oversight mechanism.

Ms SOVD TUGSDELGER (Mongolia) commended the progress made in harmonizing the work of the regional and global governing bodies. WHO's response to her country's concerns about the top-down programming for the current biennium was appreciated, and planning for the biennium 2016–2017 reflected improvements in terms of engagement with national governments to respond to country priorities. However, the time available for biennial planning was too short, and consideration should be given to a multi-year rolling work plan as a viable alternative under the reform process.

Ms PENEVEYRE (Switzerland) commended the continuing efforts to implement WHO reform but regretted that little progress had been made in managing the number of items on the agendas of the Executive Board and the Health Assembly, which had reached record highs primarily owing to a lack of discipline among Member States. There should be a sharper focus on essential strategic issues. The adoption of the Programme budget 2014–2015 had been an important step forward. It was to be hoped that the principles of bottom-up planning and results-based management would be applied to the Programme budget 2016–2017. The establishment of clear criteria for strategic resource allocation would be the next milestone. She commended the introduction of the financing dialogue, which had produced tangible results and should be continued.

Mr RAO (India) said that progress on reform implementation should be updated regularly for review by the governing bodies. There should be a particular focus on priority-setting, stronger performance assessment, increased transparency and the culture of evaluation. A more robust mechanism was needed to monitor and evaluate the contributions of each level of the Organization, in contrast to the system of routine monitoring, which relied primarily on self-reporting; independent experts should be used for that purpose. He welcomed the introduction of a web-based management

tool for monitoring reform; its use to track outputs and deliverables would enhance transparency in the context of the shift from policy analysis to implementation. Transparent implementation of WHO reforms would facilitate effective responses to global challenges, including the future financing of WHO.

Ms DRAKOPOULOU (Greece), speaking on behalf of the European Union and its Member States, said that more time would be needed to analyse the utility of the online monitoring tool, which would do much to improve the transparency of reform results and would strengthen Member States' oversight of reform implementation. She welcomed the evaluation of the financing dialogue and the strong support expressed for its continuation. The web portal and the coordinated resource mobilization strategy were important instruments for transparency and accountability, on the one hand, and improved alignment of finances, on the other. The financial and administrative implications of resolutions were also an important issue and she supported the relevant draft decision point proposed during the twentieth meeting of the Programme, Budget and Administration Committee under the item on follow-up to the financing dialogue. The slow pace of human resource and governance reforms remained a matter of concern. The Secretariat should publish documents in a more timely manner; at the same time, Member States should adopt a more disciplined approach to the setting of agendas for governing body meetings. She encouraged the Secretariat to explore the use of good practices from other areas and the Director-General to follow up on her proposal to establish sunset requirements for resolutions.

Mr KUEMMEL (Germany) said that, despite impressive progress in reform implementation, there were major shortcomings in the area of programmatic reform, requiring clarification of WHO's core work in relation to the mandate of other global health actors. The outcome of the post-2015 development agenda process would remodel the global health architecture and define the mandates of different parties; consideration must be given to reaching a better understanding of WHO's position relative to other global health actors by highlighting its specific comparative advantage. He noted with concern the slow pace of governance reform, in particular the lack of consensus on limiting the number of agenda items and the failure to find ways to strengthen common strategic decision-making. For the latter function, the Secretariat had a decisive role: it must distribute documents in good time and should shape the governing bodies' discussions by clearly specifying the issues on which it needed Member States' guidance. He commended the establishment of category and programme area networks, which should be further institutionalized. He further commended the Director-General's establishment of the Global Policy Group, which should be formally institutionalized, as recommended by the Joint Inspection Unit of the United Nations. Human resources policy was a critical reform driver and an updated report on human resources reform should be made available.

Dr DANG VIET HUNG (Viet Nam) asked for a more detailed update on programmatic reform that focused on the roles and functions of the three levels of the Organization. WHO's effectiveness depended on how those levels operated and their output. A clearer delineation of roles and responsibilities, starting from the country level upwards, would be required for the Programme budget 2016–2017. He also supported the proposal made by the delegate of Mongolia regarding rolling work plans.

Dr Villavicencio took the Chair.

Dr OKABAYASHI (Japan), welcoming the steady progress of WHO reform in all areas, urged its timely and comprehensive monitoring and assessment. Reform was a means to an end, not a goal in itself, and any adjustments in response to the challenges encountered should be made with the final objectives in mind, following a careful analysis of the issues.

Dr BINAGWAHO (Rwanda) pointed out that the African Member States were divided between two WHO regions, which gave rise to serious governance issues and created inefficiencies. The Regional Committee for Africa was not fully embedded in the African political governance body. In order to ensure that regional health decisions were implemented at country level, African governments should directly oversee the overall African health agenda, including WHO's regional agenda. Such oversight would increase efficiency by placing African priorities on the global agenda and ensuring that WHO's agenda was regularly reviewed by the African Heads of State, thereby improving ownership and implementation of the global and regional health agenda and its adaptation at national level. It would create an enabling environment for African countries to work together on the regional health agenda, reduce the number of meetings of African health ministers from separate WHO regional and African Union meetings, and ensure that interventions at the Health Assembly had the political backing of African Heads of State. An African Union Commission/WHO Joint Meeting for African Ministers of Health had recently been held (Luanda, 14–17 April 2014), at which it was decided to establish a task force to look into the necessary adaptations to the legal framework of the two bodies that would allow a single annual meeting of health ministers to be held. A proposal to that effect would be submitted to the African Heads of State.

Ms BLACKWOOD (United States of America) welcomed the progress made in programmatic, governance and management reform. There had been a noticeable increase in commitment to reform across all levels of the Organization, in particular in the regional offices. The linchpin of programmatic reform had been the Sixty-sixth World Health Assembly's adoption of the Twelfth General Programme of Work, 2014–2019 and the Programme budget 2014–2015 in its entirety. The WHO web portal would provide valuable access to budgetary and expenditure information. On the management side, steady progress had been made in several areas. She nevertheless joined previous speakers in calling for a concerted effort to implement innovative human resources reforms in order to provide the Organization with a more flexible workforce and attract talent. With regard to the lack of progress in governance reform, in the context of the debate on a framework of engagement with non-State actors the Director-General had affirmed the supremacy of Member States in making decisions. However, it was clear that a failure to act on their part meant that WHO could not exercise its mandate as the coordinating authority for global health in a manner that was in harmony with the current global health landscape. The Secretariat should be given the necessary tools to achieve reform in that area, as well as a stronger policy framework for engagement.

Ms POLACH (Argentina) commended the progress made in the three broad areas of reform, as set out in the second-stage evaluation. In particular she highlighted the improvements in health outcomes in the context of global health priorities set by Member States, improved electronic access to both governing body sessions and documents, the submission of reports from the regional committees to the Executive Board, and management reforms, including the financial dialogue. In connection with governance reform, the informal consultation and the discussion on the framework of engagement with non-State actors had raised points of view expressed by Member States that differed from those reported in document A67/4.

Mr COTTERELL (Australia), welcoming the progress made, said that it was vital to the success of the reform process that all aspects were implemented fully at all levels of the Organization. It was also essential that Member States shouldered their fair share of the responsibility, for example through continued reform of the governing bodies. He endorsed the programme of evaluation, in particular the second-stage evaluation, which the Organization seemed to have embraced, and asked whether there would be a formal response to the recommendations contained therein.

Mr DIKMEN (Turkey) expressed appreciation for the web-based management and monitoring tool with its clear and comprehensive results chain, although it needed improvement to enable Member States to provide feedback, particularly on risks, assumptions and evaluations. He wanted

clarification on the timeline for completion of the tool; on the target dates for outcomes that were set earlier than the relevant outputs; and on budget components whose implementation level was low. Member States were responsible for fulfilling their commitments to ensure that the reform process remained on track; that called for self-discipline and changed attitudes in order to reduce the number of agenda items, to improve the quality of governing body meetings, to evaluate the implementation of resolutions and decisions, to make the necessary adjustments, including sunseting, where appropriate, and to ensure that the financial implications of proposed resolutions were based on realistic cost calculations.

Ms ZHANG Yang (China) suggested that increased collaboration with and between Member States was needed to give impetus to the reform process. Although the adoption of the Programme budget 2014–2015 in its entirety had been a welcome development, a bottom-up, country-led method of budgeting that more accurately reflected the Organization's costs should be used for the next biennial budget. That would also allow outputs and deliverables to be costed in an open and transparent way. She commended the establishment of the Global Network on Evaluation and the useful results it had produced. However, the low participation of WHO staff members in the network's survey should cause senior management to reflect. WHO needed to extend the discussion of governance reform to include other organizations dealing with health issues, with a view to maintaining its intergovernmental nature without sacrificing its inclusiveness. She commended the Secretariat on the measures taken to reduce administrative and management costs and on its efforts to strengthen human resources reform in order to attract and keep the best talent and increase efficiency. WHO, as a technical organization, should fully exploit its technical advantages and combine them with relevant country policy priorities in order to advance bottom-up programme reform, while reinforcing its leadership role in global health. The reform process should be institutionalized without further delay.

Dr SMITH (Executive Director, Office of the Director-General) thanked delegates for their comments. Further details on progress on reform were available on the WHO website. The Organization had responded to the second-stage evaluation of the reform through a report noted by the Executive Board in January 2014¹ and the report to the current Health Assembly (document A67/4). The evaluation team's recommendations had been accepted and were being acted upon but a detailed response to all 46 specific recommendations had not been provided. The programme management tool was posted on the WHO website.² It provided details of the plans, current status and budgets for reform and the results being achieved, thus ensuring transparency and accountability. He invited feedback on the usefulness of the tool. Further work was needed on the indicators and targets for reform and the Secretariat would be undertaking that soon. Referring to the need that had been highlighted for a rapid shift from policy analysis to implementation of the reform, he said that the programme management tool would assist in ensuring effective planning of that shift and prioritizing work at the appropriate levels. He concurred that it was vital to engineer real change at the country level, and accountability and resources therefore had to be guaranteed for country support. It was also essential to set priorities, improve performance and maintain a focus on independent evaluation, and further progress needed to be made in the priority area of human resources in 2014. WHO reform, which was currently in its third year, was an ongoing process designed to create an Organization that was continuously responsive to the changing environment and to Member States' needs. The Secretariat would deliver on the results expected of it and continue to report to the governing bodies on the progress made.

¹ See summary records of the fifth meeting of the Executive Board at its 134th session (document EB134/2014/REC/2).

² <http://spapps.who.int/WHOREform/SitePages/Reports/Dashboard.aspx>.

The DIRECTOR-GENERAL thanked delegates for their valuable interventions and guidance. She recalled that the objective of WHO reform, as discussed and agreed by the Member States, was to ensure the relevance, effectiveness and transparency of the Organization, and to guarantee its accountability for delivering results with the resources at its disposal. She shared the concern that had been expressed about the slow progress in the crucial area of governance reform.

As far as internal governance was concerned, Member States were anxious to avoid the burden of a heavy agenda and to be able to focus on strategic discussion, for which purpose they relied on the Secretariat to produce documents in a timely manner. However, that requirement could not always be met if protracted intersessional consultations and negotiations encroached on the time available for preparation of governing body sessions. She would review the situation, and where the demand for documents exceeded capacity, notification would be provided via the WHO website. Member States had to tailor their expectations to their willingness to pay for them: output had to be reduced or resources increased. The Global Policy Group and lessons learnt from the category and programme area networks would be institutionalized. Regional directors at the Global Policy Group meeting had reported that the networks had fostered a more corporate approach to work across the three levels of the Organization.

On the issue of external governance, a balance had to be struck between Member States' sovereign decision-making power and the need for the Organization to be inclusive. She therefore encouraged Member States to take small but tangible steps to promote engagement with non-State actors. Oversight mechanisms could be established to ensure progress in that direction, which was necessary in order to maintain the relevance of WHO as a directing and coordinating global health authority and to set the stage for the exercise of Member States' leadership in relation to the fast-approaching post-2015 development agenda.

The Committee noted the report.

The meeting rose at 12:00.

THIRD MEETING

Tuesday, 20 May 2014, at 15:45

Chairman: Dr P. RENDI-WAGNER (Austria)

1. PROMOTING HEALTH THROUGH THE LIFE COURSE: Item 14 of the Agenda

Monitoring the achievement of the health-related Millennium Development Goals: Item 14.1 of the Agenda (Document A67/19)

- **Health in the post-2015 development agenda:** Item 14.1 of the Agenda (Document A67/20)

Mr PARIRENYATWA (Zimbabwe) requested that a drafting group be established to consider a draft resolution on agenda item 14.1, health in the post-2015 development agenda, which had been submitted by the Member States of the African Region.

The CHAIRMAN said that, if she heard no objection, she would take it that the Committee agreed to the establishment of the drafting group.

It was so agreed.

(For resumption of the discussion, see page 58.)

2. WHO REFORM: Item 11 of the Agenda (continued)

Improved decision-making by the governing bodies: Item 11.2 of the Agenda (Documents A67/5 and A67/5 Add.1)

Dr ARMSTRONG (Secretary) introduced document A67/5, which set out recommendations from the Executive Board on improved decision-making by the governing bodies and contained a draft resolution, the financial and administrative implications of which were set out in document A67/5 Add.1. He recalled that during its 134th session, the Board had discussed the use of an electronic voting system for the appointment of the Director-General, electronic access to documents, managing the number of agenda items, minimizing the late submission of draft resolutions and documents, and reform of reporting requirements.¹

¹ See summary records of the fifth and twelfth (section 4) meetings of the Executive Board at its 134th session (document EB134/2014/REC/2) and decision EB134(3) on WHO reform: methods of work of the governing bodies (document EB134/2014/REC/1).

Ms GHEBRESELASIE (Norway) said that the governing bodies must be able to conduct their business in an effective manner. She particularly supported recommendation 4 in document A67/5, as consideration of progress reports only by the Health Assembly was expected to lead to richer discussions.

Mrs TYSON (United Kingdom of Great Britain and Northern Ireland) welcomed the report. She urged more rapid and substantive progress on governance reform, and recalled that considerable appetite had existed at the 134th session of the Board for hard decisions on controlling the number of agenda items until the Director-General had urged members to refrain from such action. Noting with regret that some of the concrete ideas put forward at the Board had not yet been tested, she said that, although Member States had a part to play in developing more manageable agendas, ensuring the more responsible development and follow-up of resolutions, and in achieving better understanding and control of resource allocation, the Secretariat must also assume a leading role in providing guidance. She supported the draft resolution as a welcome, albeit small, step in the right direction.

Miss ORRATAI WALEEWONG (Thailand) appreciated the Secretariat's continuing efforts in respect of WHO reform, but the four recommendations did not reveal how decision-making by the governing bodies would be improved; she asked how they would "contribute to greater coherence in global health and the strengthening of WHO's governance" as stated in document A67/5 Add.1. She sought further information on the rationale of using electronic voting for the election of the Director-General, highlighting the importance of a well-designed technical system and data security in order to ensure integrity, confidentiality, transparency and confidence. Given that the cost-effectiveness of new methods should be proven, further consideration of the choice of an electronic voting system should be given by the Executive Board at its 138th session in order to ensure that WHO was able to benefit from any developments in technology in the intervening period.

Dr AMMAR (Lebanon) agreed with the delegate of the United Kingdom of Great Britain and Northern Ireland that it would have been preferable to establish more selective mechanisms for the introduction of new agenda items in order to make governing body meetings more manageable and efficient. It was regrettable that no consensus had been reached. Furthermore, the webcasting of Health Assembly meetings, while welcome, might increase the number of interventions and prolong the deliberations. Although he supported the draft resolution, the effectiveness of the work of the governing bodies should be discussed again in the near future.

Dr AL-TAAE (Iraq) expressed support for the draft resolution. Improved decision-making by the governing bodies could be achieved through the implementation of a high-quality work plan, the use of benchmarks, the introduction of webcasting through an appropriate electronic governance application and action plan, and the provision of capacity-building at the institutional and personnel levels.

Mr DIKMEN (Turkey) attached particular importance to efforts to increase the efficiency, transparency and accountability of the Organization and its decision-making bodies, and requested further clarification of the financial impact of the proposed draft resolution, notably on cost calculation, breakdown and funding options.

Mr BURCI (Legal Counsel), welcoming the support expressed, said that the Director-General shared the frustration of Member States over the slow pace of governance reform. The draft resolution should be read in conjunction with decision EB134(3), which proposed other steps, including the requirements for the explanatory memoranda for the introduction of new agenda items, that might make Member States more accountable when introducing additional items. Although the draft resolution might not go as far as some Member States wanted, it should be considered as a step in the right direction.

Electronic voting was being proposed for the election of the Director-General because the election method had been reformed. The Executive Board would, in principle, nominate three candidates to be voted on by the Health Assembly in a secret ballot, and multiple votes might be required until one candidate obtained the required majority. The introduction of electronic voting would speed up voting considerably, and minimize disruption to the work of the Health Assembly. The Board was recommending that the Health Assembly accept the rental of equipment to ensure that any advances in technology would be reflected in the equipment rented. The system and equipment in question were already used by WMO, and he was not aware of any issues regarding the security and confidentiality of secret ballots performed electronically. Should there be major progress or unexpected developments, the Secretariat would report to the Board and the Health Assembly. The Board had decided to review the issue at its 138th session, in 2016.

Mrs ROSE-ODUYEMI (Office of Governing Bodies) said that, as indicated in document A67/5 Add.1, the cost for the biennium 2014–2015 (to be incurred for the Sixty-eighth World Health Assembly in 2015) was estimated to be US\$ 200 000. After minor reprogramming, the cost would be covered within the Programme budget 2014–2015. The amount for the biennium 2016–2017 was estimated to be US\$ 320 000 and related entirely to the cost of the webcasting equipment and the relevant technical support.

The draft resolution was approved.¹

Follow-up to the financing dialogue: Item 11.4 of the Agenda (Documents A67/7, A67/8 and A67/54)

The CHAIRMAN, introducing the item, also drew attention to a draft decision by the Programme, Budget and Administration Committee, on behalf of the Executive Board, entitled Consideration of the financial and administrative implications for the Secretariat of resolutions proposed for adoption by the Executive Board or Health Assembly and contained in document A67/54.

Dr ASMA GALI (Niger), speaking on behalf of the Member States of the African Region, highlighted the importance of predictability, flexibility and transparency and welcomed the Secretariat's efforts to promote the financing dialogue and the follow-up actions to attract new contributors, broaden the contributor base and promote a longer-term view of organizational funding (document A67/7). She praised the independent evaluation. The financing dialogue was an important resource mobilization tool that should continue, taking into account the lessons learnt and the need to align WHO's resource requirements with health priorities. It increased the visibility of WHO and its time horizon should be extended. In the African Region, priority was being given in national programmes to strengthening the actions and commitment of finance and health ministries towards their partners in order to improve dialogue between countries and the formulation of improved strategies and plans in order to promote optimization of resources, sustainability and reliability in the health sector.

Mr ELIAS (Ethiopia) expressed support for the efforts of WHO and development partners to increase transparency and aid effectiveness, in line with the principles of the International Health Partnership (IHP+), the Paris Declaration on Aid Effectiveness and the Busan Partnership for Effective Development Co-operation. He welcomed WHO's commitment to the principles of predictability, alignment, flexibility, transparency and accurate reporting of results, which were indispensable to a highly coordinated health response in a resource-constrained setting. Resource limitations in low- and

¹ Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA67.2.

middle-income countries might need further special financing modalities to achieve future targets. His Government strongly supported WHO's work on improved financial management and would strengthen its efforts to increase domestic financing and align available resources with global and country-specific priorities.

Dr AMMAR (Lebanon) said that the financing dialogue had provided a forum for the generation of new ideas and mechanisms for better alignment, flexibility and expanding the contributor base, and he welcomed the results achieved. It should continue beyond the biennium 2014–2015. The commitment to fund administration costs fully could be met only if the real costs of WHO's programme of administration and management were built into voluntary contribution agreements, replacing existing service charges. He would welcome feedback on the responses received from Member States concerning supplements to assessed contributions, and suggested that more formal solidarity mechanisms be adopted to fill financial gaps at regional levels. He supported the draft decision contained in document A67/54.

Dr REDDY (India) said that the financing dialogue was a key component of WHO reform and was essential for alignment, transparency, predictability and flexibility of funding, to broaden the contributor base and to ensure that WHO was well-equipped to address the increasingly complex challenges of global health in the 21st century. As a general principle, the post-2019 programme of work and budgetary support should be linked to the health concerns and risk factors of the regions and Member States and the global burden of disease. Such action would give Member States and other donors more confidence in committing greater and more flexible funding to WHO's core budget. He welcomed the progress towards the transparent implementation of the WHO reform process, the ongoing financial dialogue and the proposed set of follow-up actions, and the steps taken to incorporate the financial analysis and updates in the programme budget web portal. He advocated greater transparency in expenditure management across the six broad categories of work, specific programmes, the regions and the three levels of the Organization.

Ms DUSSEY-CAVASSINI (Switzerland) said that the financing dialogue, which her country supported, had helped to promote confidence and understanding. She favoured the proposal to hold bilateral meetings with those contributors that had not yet committed funding, emerging States and non-State actors with a view to identifying funding aligned with the priorities set out in the programme budget. She welcomed the lessons learnt from the financing dialogue which, it was hoped, could be shared with others outside WHO, and supported the draft decision, which recognized the need to consider alignment of resolutions with WHO's priorities. The implications of resolutions should also be linked to their ever-increasing number.

Ms HERNÁNDEZ NARVÁEZ (Mexico) affirmed that the financing dialogue was a valuable exercise. She commended the progress made by the Secretariat, encouraging it to apply the recommendations of the independent evaluation. The programme budget web portal, an indispensable means of communication and strategic orientation for decision-making, had to be improved. As indicated in the independent evaluation, the information it provided lacked accuracy, timeliness and relevance. In particular, it should provide more detail about underfunded categories, broken down by region. One year earlier, when the Member States had approved the Programme budget in its entirety, they had undertaken to align funding with the programme budget. The financing dialogue had facilitated progress to that end, but adequate mechanisms still had to be found for dealing with the financial and administrative implications of the resolutions adopted by the Health Assembly. Frank and informed discussion was needed in the face of the imperative to strengthen the alignment of resolutions with the General Programme of Work and the programme budgets. She firmly supported the proposed draft decision.

Mr KOLKER (United States of America) said that the financing dialogue and independent evaluation, which he welcomed, had advanced understanding of WHO's role and value for money. It had resulted in an improved financial outlook for the biennium 2014–2015, and promoted greater transparency, predictability, alignment, sustainability and accountability. He drew particular attention to the web portal, which provided information on the use of contributions and a more realistic conception of what WHO could be expected to accomplish within its budget. He requested clarification on alignment of the Organization-wide resource mobilization efforts to meet shortfalls and on the application of the 20% of assessed contributions that had not been allocated. In the interests of expanding the donor base of WHO, he encouraged the Secretariat to submit to the Programme, Budget and Administration Committee at its next meeting estimates of the notional share of voluntary contributions that countries should consider providing.

Mr HOLM (Sweden), speaking on behalf of the Nordic countries, Denmark, Finland, Iceland, Norway and Sweden, said that the financing dialogue had contributed to more transparent, effective and predictable financing, and that it had helped to promote coordination within the Secretariat and in Member States. Although 85% of the programme budget was funded, the shortfall, especially in areas such as noncommunicable diseases and preparedness, remained a concern. The crucial test of the new financing model would be to distribute funds in line with the programme budget. As the independent evaluation had concluded, WHO should have a single, centrally-coordinated resource mobilization strategy linked to the programme budget, and he sought more information on how a coherent strategy would be secured for the current budget. He highlighted the importance of maintaining and developing the web portal, including a facility for reporting on the use of core voluntary contributions and the results obtained. He supported the draft decision, which provided a pragmatic way forward to deal with the cost implications of resolutions that had not been provided for in the programme budget.

Ms SURIWAN THAIPRAYOON (Thailand) urged the Director-General to give priority to increasing transparency in the budgetary and funding processes. The core value of the financing dialogue should be taken into account in order to ensure the cost-effectiveness in the use of limited resources, and the format of the financing dialogue should be changed to create an enabling environment for innovative discussions.

Dr MAKUBALO (South Africa) fully supported all measures taken to improve predictability, transparency, reporting and accountability, and affirmed the financing dialogue as a useful process that had already yielded encouraging results. It should be anchored within a broader resource-mobilization strategy, which would help to promote sustainability. Reaffirming the importance of aligning funding with priorities and supporting the proposal to reallocate funds from oversubscribed areas, she expressed support for the draft decision.

Dr CHO Enhi (Republic of Korea) said that the Republic of Korea had continued to expand the size of its voluntary contribution to WHO, despite the health ministry having experienced difficulties in demonstrating to the ministry of finance value for money and appropriate programme management. She therefore welcomed the Secretariat's decision to provide contributor benchmarking information. Contributing countries should agree on what information to submit to WHO and update it annually.

Ms ZHANG Yang (China) supported the nine recommendations of the independent evaluation. She called for enhancement of the web portal to increase transparency, and for greater flexibility on the provision of voluntary contributions. Efforts should be made to improve the format of meetings and to encourage the participation in the financing dialogue of technical staff and of more countries. Noting the importance of ensuring that funding was aligned with agreed priorities, she said that the contributor base should be expanded within an improved framework for cooperation with non-State actors in order to avoid any conflict of interest or risk. The financing dialogue should not simply serve

to mobilize resources for WHO itself; rather, it should enable the Organization to achieve results and play a vital role in the health sector on a global scale.

Mr DIKMEN (Turkey) attached great importance to the financing dialogue process, which increased transparency, accountability, communication and predictability. The programme budget web portal, whose introduction was welcome, could be improved so as to enable voluntary contributions to be tracked. He recalled that the earmarking of funds limited budgetary flexibility and requested the Secretariat to provide information about the percentage of earmarked voluntary contributions by activity, programme and category.

Dr AL-TAAE (Iraq), expressing full support for the draft decision, said that programmes should be financed according to priorities based on national epidemiological and demographic variables. Furthermore, financing should respond to the need for capacity-building in a country and take into consideration the financial capabilities of other organizations in the United Nations system, donors and entities within a work plan aimed at the integration of financial resources. Cost-sharing with a country should be used judiciously for the expansion of financial planning. Such steps had been included in Iraq's recently released national health policy.

Dr KISAKA (Japan) expressed support for the draft decision. The financing dialogue should help to improve the alignment of the programme budget with available resources, streamline WHO's financial situation and facilitate the reform process. A certain level of flexibility was essential in order to maximize the outcome of WHO's activities, but accountability to taxpayers resulted in earmarked funding. Consideration should be given to the provision of incentives for Member States to increase the flexibility of funding.

Mr KUEMMEL (Germany) recalled that, from the outset, the Director-General had highlighted that the financing dialogue, which was improving understanding of WHO's financing, was a joint learning exercise for Member States and the Secretariat. Its success depended on improving current methods of resource mobilization and moving away from decentralized and uncoordinated fundraising towards an approach where the programme budget was the main accountability tool under the leadership and coordination of the Director-General. He sought further information on how and when the remaining 20% of assessed contributions would be allocated to the major offices.

Mr DEANE (Barbados) welcomed improvement of the alignment, predictability, flexibility and transparency of WHO's funding, and the identification of mechanisms to ensure predictability of the budget. The financing dialogue had yielded good results. He supported the programme budget web portal as a tool to strengthen planning and budgeting for both Member States and the Secretariat. Such a bottom-up approach would help to ensure that programmes were aligned with financing at all levels of the Organization and promote transparency and results management. A reasonable time frame should be given for the provision of feedback and training to Member States where appropriate. His Government looked forward to continuation of the dialogue to strengthen the financing of the general programme of work.

Dr RATIH (Indonesia) said that in order to achieve its objectives, WHO must align its work with the needs and priorities of countries and thereby increase national ownership. Consideration should thus be given to a policy of increasing the number of locally recruited technical staff and to promoting the use of locally produced health products or services that complied with WHO's standards and regulations. She supported the move towards integrated budget management and would welcome the further engagement of WHO in United Nations efforts to promote financial inclusion.

Dr TROEDSSON (Assistant Director-General) thanked the Member States for their support and input concerning the Organization's funding. The Secretariat had taken note of Member States' guidance and would ensure that all future financing was aligned with the programme budget in a transparent and accountable manner. The Director-General had taken steps to improve the coordination of Organization-wide resource mobilization in order to ensure the full financing of the Programme budget 2014–2015, and would extend such measures to cover the programme budget for 2016–2017. The Secretariat intended to produce a financing strategy for the Executive Board's consideration in 2015, which would include a section on coordinated resource mobilization as well as budgeting, costing and resource management, monitoring and reporting. In addition, the programme budget web portal would be enhanced to include more detailed and up-to-date financing information in an effort to improve the predictability, alignment, flexibility and transparency of WHO's funding and reduce its vulnerability.

In response to questions about the allocation of assessed contributions and additional voluntary contributions, he said that all funds would be deployed in a strategic manner to ensure that every programme received sufficient operational funding for a minimum period of six months. The non-distributed 20% of assessed contributions and the funds in the core voluntary contributions account had been set aside to cover any shortfalls in programme financing and would be used where most appropriate. As to supplementary assessed contributions, he thanked South Africa for its positive response to the Secretariat's request and hoped that other Member States would follow suit.

The DIRECTOR-GENERAL encouraged Member States to uphold their political commitment to widening the Organization's donor base and follow the example set by South Africa with regard to supplementing assessed contributions on a voluntary basis. With regard to the proposal for the introduction of incentives, the Secretariat would look into the possibility of providing such measures for countries that provided additional voluntary contributions but she called on Member States to demonstrate their willingness to take up such incentives. As to the organization of the financing dialogue, she stressed that all Member States and their technical experts could participate in financing discussions and the Secretariat welcomed their input. With regard to increasing cost-sharing between Member States and the Secretariat, she thanked Iraq for its proposal and welcomed all offers of additional support.

The draft decision contained in document A67/54 was approved.¹

Strategic resource allocation: Item 11.5 of the Agenda (Document A67/9)

Dr WARIDA (Egypt), speaking on behalf of the Member States of the Eastern Mediterranean Region, acknowledged the work of the Working Group on Strategic Resource Allocation and agreed that the development of the new strategic resource allocation methodology would require extensive efforts and careful analysis. The methodology should be aligned with the principles of WHO reform that had been endorsed by Member States in 2013. He agreed that technical support should be strengthened at the country level, and that it should be included in the guiding principles for the development and implementation of the new methodology. That process would require a reinforced country presence, which should be taken into account when reviewing the distribution of the programme budget across the four operational segments.

Dr PRAKASIT KAYASITH (Thailand) said that the criteria for developing a resource allocation strategy should be clear, unique and based on values and available resources, whereas the current criteria were unclear and contained many indicators that would be difficult to apply. He expressed concern about the lack of availability or accuracy of data relating to the proposed indicators,

¹ Transmitted to the Health Assembly in the Committee's second report and adopted as decision WHA67(8).

particularly in low- and middle-income countries and proposed instead giving priority to indicators related to WHO's Twelfth General Programme of Work, 2014–2019 and the Millennium Development Goals and to obtaining data in areas such as noncommunicable diseases. He requested that the Working Group prepare a plan for the complete priority-setting cycle, to include criteria selection, weighting, scoring, stakeholder involvement, and how and when to support the health priority proposals.

Ms GHEBRESELASIE (Norway), speaking on behalf of the Nordic countries, Denmark, Finland, Iceland, Norway and Sweden, supported the Organization's strategic use of resources and the proposed guiding principles. She also welcomed the proposal to change the title of the initiative to "strategic budget space allocation". Results-based management was essential to any viable strategic resource allocation system, and that approach was not adequately reflected in the report. The system being designed should be based on needs and evidence and take into account the differing roles and functions for each policy area and target. There was also a need for a clear system for costing outputs in order to underpin the development of the methodology and enable an objective assessment of results.

Ms OSPINA (Colombia) emphasized the importance of strategic resource allocation within the reform process, as the new methodology and criteria would ensure equitable regional participation. Communication mechanisms between Member States and the Secretariat, such as the financing dialogue and the Working Group on Strategic Resource Allocation, promoted a culture of accountability and ensured equal regional participation. However, it was important to review the difficulties in implementing the previous strategic resource allocation methodology, and determine whether a new methodology based on real costs would be implemented more easily. In addition, taking into account the ongoing reform process, a transitional methodology might be necessary, to be adapted later to the final post-reform structure. Finally, it was important to have more detailed information about administrative costs, in order to continue to promote efficient results-based financial management.

Mr KUEMMEL (Germany) said the new methodology was a priority for his country, although he recognized the complexity of developing a mechanism that was perceived as fair by all stakeholders. He recalled that neither of the two previous attempts that had been made to develop such a methodology had been comprehensively implemented because not everybody had perceived it as fair. Although it was unlikely that a strict resource allocation algorithm would be considered fair by all, he agreed with the guiding principles established by the Working Group.

Dr AL-TAAE (Iraq) said that any strategic resource allocation methodology should relate to a country's epidemiological and demographic variables, prioritize community needs and take into account the need for personnel and institutional capacity-building. Any methodology should also be incorporated into national strategic work plans.

Dr TSESHKOVSKY (Russian Federation), welcoming the results of the Working Group, noted that under segment 2 there was a need to ensure resources for innovative developments in regional and global goods, in order to sustain WHO's leading role in global health. Concerning segment 4, WHO had been supporting countries facing unexpected emergency events for many years, and he proposed the creation of a reserve fund for the next two years whose size would be estimated on the basis of average annual expenditure over the previous 10 years. Finally, the development of the methodology should be intensified, and should include intellectual resources, in order to be able to shape the preparation of the programme budget for the biennium 2016–2017.

Ms HERNÁNDEZ NARVÁEZ (Mexico), speaking on behalf of the Member States of the Region of the Americas, said that strategic resource allocation was a regional priority within the wider context of the WHO reform process. She supported the guiding principles, and encouraged the application of key principles in finalizing the programme budget for the biennium 2016–2017. The provisional criteria for each operational segment provided a solid basis for future work, and the current dynamic should be maintained, in order to finalize the methodology by January 2015.

Ms CHARTON (Switzerland) welcomed the proposal for a new strategic resource allocation methodology, and agreed with the guiding principles for its development, although specific percentages should not yet be allocated to the different operational segments. Although she recognized the benefit of reflecting on past experience, it was important to face current and future challenges, which meant ensuring the methodology was needs-based.

Regarding segment 1, and noting that responsibility for technical cooperation was being transferred to country level, a criterion on national capacity should be added in order to develop robust country cooperation strategies and support implementation of national investment plans. Financial and programmatic risks should also be taken into account. Segment 2 should include a criterion on the comparative advantage of the Organization, which would require WHO to have a clear vision of global health and its role therein. She welcomed the proposal on administrative and management costs referred to under segment 3, which reflected the Secretariat's work to define and clarify them.

Strategic resource allocation should accompany resource management and, if the new methodology were implemented, Member States would need to accept that strategic budget allocation would guide resource allocation in the future. Flexibility was essential to ensuring that the methodology did not simply become an allocation of non-earmarked funds.

Ms SOVD TUGSDELGER (Mongolia) requested that WHO reaffirm its commitment to supporting poor populations within countries, particularly in middle-income countries. Economic growth and disproportionate health budget increases were leading to a “growing number of rich countries full of poor people”, as the Director-General had warned.¹ As scaling back development assistance to those countries put in need the people at greatest risk, she proposed including an explicit indicator on social equity under segment 1 as a criterion for determining the country profile in respect of strategic resource allocation. She called on donors with fully-funded programmes to reallocate their funds to underfunded areas.

Mr COTTERELL (Australia) supported the guiding principles and the proposed way forward. He emphasized that a binding mathematical algorithm would unnecessarily tie the hands of the Director-General and regional directors, and would not provide stable funding for the different levels of the Organization and the various programme categories. There was a need for flexibility in order to respond to emerging issues and emergencies. In that context, he supported a principles-based approach.

Professor ELIRA DOKEKIAS (Congo), speaking on behalf of the Member States of the African Region, noted the progress made by the Working Group, which was an essential part of the reform process. The completion of the process would facilitate more transparent and predictable budget allocations and, above all, would ensure that countries received support in proportion to their needs. The Regional Committee for Africa would consider the proposals at its next session, but he noted in the meantime that the guiding principles appeared relevant and timely.

The criteria to be applied in respect of technical cooperation at country level should ensure the strict collation of indicators, as that would determine the contribution to be received by each country. Each Member State in the Region was currently analysing its needs, in line with the bottom-up

¹ Document A67/3.

planning approach, and he asked the Secretariat to provide support at country level. Noting the proposed way forward, he hoped the process would be concluded quickly, so that the principles could be taken into account in finalizing the programme budget for the biennium 2016–2017.

Ms BURRIS (United States of America) supported a resource allocation methodology that was designed for WHO's structure and operated on the basis of realistic costing, and that reflected the key principles. The information in the report represented a good basis for future work. It was important that the development process, the resulting methodology and the allocation were perceived as being fair. There were direct linkages with resource mobilization, efforts to increase predictable and flexible resources and more realistic costing, all of which would create a stronger Organization. She looked forward to a proposed new methodology for adoption at the next Health Assembly.

Dr DANG VIET HUNG (Viet Nam), welcoming the report, said that under segment 3 the Secretariat should focus on cost-effective administration and management, and attempt to reduce related costs. It should establish a ceiling for administrative and management costs, as a percentage of the budget, in order to increase funding for technical areas. Under segment 4, he requested adding "other epidemic outbreak eradication" after "poliomyelitis eradication" in paragraph 19 of the Annex to document A67/9, in order to ensure a focus on emerging epidemics in developing countries. He supported the proposed way forward.

Mr ŞEN (Turkey) said that development of the new methodology required a comprehensive understanding of the planning, implementation and assessment cycle, and the link between resource allocation and resource mobilization and management. The methodology would have an impact on the distribution of assessed contributions and should be extended to cover voluntary contributions. Although approval of the programme budget in its entirety marked an important change, more needed to be done to influence attitudes and promote flexible funding.

The report was a good basis for future discussions, although understanding of new terms such as "segment" would be assisted by the provision of a clear definition of the link between categories and priorities, and the division of labour across the three levels of the Organization. He asked the Secretariat to provide current budget allocations for each segment, and to indicate where change was expected, in order to enable a better assessment of any progress made. Resource allocation was an important component of the reform process, but its interaction with other components should be taken into account, including lessons learnt from the financing dialogue. An updated document should be submitted to the Executive Board in January 2015, so as to feed into discussions on the programme budget for the biennium 2016–2017.

Ms SAMIYA (Maldives) appreciated the progress made to date, but noted that much remained to be done in order to make the new methodology meaningful and applicable. Although the methodology would not be used to determine resource allocations during the 2016–2017 budget cycle, the key principles should be used in preparing the programme budget for that biennium.

Ms ZHANG Yang (China), supporting the methodology on strategic resource allocation, welcomed the three pillars for the methodology and approved the seven guiding principles contained in the report as they would increase transparency and accountability in resource allocation. Robust bottom-up planning should be more effective, so as to clarify the responsibility of Member States. She hoped that further progress would be made while developing the proposed programme budget for 2016–2017.

Dr TROEDSSON (Assistant Director-General) thanked Member States for their views, and the Working Group for its hard work and guidance. As several delegates had pointed out, strategic resource allocation was a complex task, owing to the comprehensive agenda and wide-ranging

functions of WHO. Strategic budget space allocation was difficult, both in terms of its distribution across the Organization, and to specific areas and programmes.

Although it was important to consider past experiences, the current situation was very different from that in 1998 and 2006 as a result of global socioeconomic and public health developments. It could be seen as an ongoing, evolving process.

The Programme, Budget and Administration Committee had agreed that the title of the initiative should be changed to “strategic budget space allocation” because it better reflected the discussion, which centred on budget space rather than money. However, it was true that the initiative could not be seen in isolation; he agreed that it should be linked to resource management and results-based management, and other elements of the reform process.

Concerning the comments on the issue of predictability versus flexibility, although a single mathematical algorithm would not be appropriate, it was essential to develop an agreed methodology to guide budget space allocation. Nevertheless, when planning a biennial programme budget, it was not possible to know the situation at the end of the corresponding biennium, and the Director-General therefore required flexibility for reprogramming and to respond to emerging needs.

Recalling the comments made by the delegate of Turkey on evaluating the changes made, the proposed methodology would be tested by applying it to the existing Programme budget 2014–2015, thereby providing important information on whether it was realistic.

Responding to the comments made by the delegate of Maldives, he said that any agreed elements of the methodology would be used in finalizing the proposed programme budget for 2016–2017, even if it was incomplete. In addition, the regional committees would provide valuable feedback throughout the ongoing process.

Finally, as noted by the delegate of Mongolia, WHO’s support for middle-income countries went beyond current budget space allocation; for example, it included supporting financially-vulnerable Member States in meeting their obligations resulting from the post-2015 development agenda, and that had to be included in the new methodology, under segments 1 and 2.

The Committee noted the report.

Financing of administrative and management costs: Item 11.6 of the Agenda (Documents A67/10 and A67/54)

Dr AL-TAAE (Iraq) stressed the need to reduce unnecessary administrative and management costs, in collaboration with each country. Moreover, the clarification of roles between the Secretariat and countries would ensure that programmes were successfully implemented and resources were not wasted, particularly in the area of administration and management. Countries should also work with the Secretariat on joint financial planning, to facilitate the best investment of financial resources, and on joint monitoring and evaluation, to ensure a better control of management costs.

Mrs LARUE (Seychelles), speaking on behalf of the Member States of the African Region, said that the effort and resources being invested in the reform process were long overdue. At a time of growing needs and challenging funding opportunities, administrative and management costs were unlikely to decrease, and would be perceived as an increased percentage of the budget compared with programmatic needs. Further reductions in those costs could increase risk, as had been noted by the internal and external auditors.

By grouping together administrative and management costs, it was possible to change the budgeting and financing of such expenditure. Currently, such costs were spread across the six categories of the programme budget, and were often impossible to determine and report on. In addition, the misalignment between funding allocations and country priorities should be rectified.

She supported the approach for budgeting administrative and management costs across the Organization, starting with the biennium 2016–2017. She noted the proposal to finance stewardship and governance costs under Category 6 of the programme budget from assessed contributions,

although not all regions or countries had sufficient allocations to fully meet those needs. In assigning resources to major offices, country specificity and risk identification should be taken into consideration. She agreed that the administrative and management costs could be broken down into two components of direct and indirect costs, as identified in the report.

Dr JARUAYPORN SRISASALUX (Thailand) noted the importance of the report for effective budgeting and resource management and rectifying previous misuse of accounting categories. The costs of stewardship and governance, which were essential management functions, were funded primarily from voluntary contributions, which were unpredictable. The proposal to fund such costs from assessed contributions, in order to provide increased financial security for personnel, was welcome. However, there should also be an increase in assessed contributions, which were relatively small. She accepted the proposal on financing infrastructure and administrative support in principle, provided that the budget or contributions were predictable and flexible. WHO should continue dialogue with donors on financing, and conclude the framework of engagement with non-State actors, so as to broaden the contributor base. She agreed with the recommended approaches for defining the budget and for financing administrative and management costs.

Dr AMMAR (Lebanon) reiterated his concerns regarding the financing of administrative and management costs principally from assessed contributions, including the programme costs that were funded from voluntary contributions. The cross-subsidization of costs had increased over the years, and, if it continued, would threaten the sustainability of administration and management. It also hindered the principles of good governance. Programmes could not be evaluated if significant parts of their costs were disguised. Fragmented financing did not promote accountability or transparency.

Although stewardship and governance would be presented as a separate budget item, he proposed that they should still be attributed to different categories and programmes, by identifying cost drivers, which would enhance transparency and analysis of cost-effectiveness.

He welcomed the idea of non-earmarked voluntary contributions, and proposed that such contributions be subject to lower charges, rather than being exempted from them.

Dr KISAKA (Japan) welcomed the approach taken, recognizing the importance of structural reform and the necessity to increase transparency. The outcomes of such efforts should be evaluated and assessed by Member States. Full accountability would lead to an increase in the flexibility of contributions made.

Mr BEDFORD (Australia) strongly supported the proposed approach as it was logical, realistic, fair and transparent. He noted that more information on an overall financial strategy would be submitted to the Executive Board in January 2015, and looked forward to receiving more detail on how the differential programme support rates would be determined and applied. Member States would require time to consider the implications of any new approach. Transparency was essential in generating confidence in the financing and budgeting process, and he welcomed the progress made in that regard.

Ms POLACH (Argentina) supported the work undertaken by the Working Group and the proposals made by the Programme, Budget and Administration Committee, which should be further analysed for the preparation of a new methodology. She agreed with the scope and guiding principles laid out in the document. The criteria indicated under segments 1 and 2 would be a good base for future work, but those under segments 3 and 4 required further analysis. She supported the proposed way forward, and asked for more information about how the information would be reviewed before the regional committees.

Mr DARR (United States of America) supported steps to improve clarity in budget preparation and programme execution, which included better definition and monitoring of administrative and management costs. He appreciated efforts to ensure appropriate financing of administrative and management support and cost containment in those areas. Voluntary sources of funding should bear their share of overhead costs, and he supported a mix of the proposed options in order to minimize the risk of WHO continuing to be over-reliant on assessed contributions in that area. He supported the Secretariat's approach and further dialogue on the subject, and appreciated that the dialogue had already begun to help in the preparation of the programme budget for 2016–2017.

Mr AL-ABDULLA (Qatar), welcoming the report, maintained that delegations attending meetings of the present kind should include experts in administration and budgeting in the interest of drawing up short- and long-term plans for the implementation and development of a strategy for costs and expenditures relating to the budget. The current discussions had been repeated over several years, resulting in ever-increasing costs. They should be brought to a close and action taken.

Mr JEFFREYS (Comptroller) thanked Member States for their supportive comments, which would be considered, and the revised approach contained in document A67/10 would be followed for the preparation of the programme budget for the biennium 2016–2017. The provisional budget proposals presented to the regional committees would include the proposed principles.

Responding to the concerns regarding assessed contributions, raised by the delegate of the Seychelles, the proposals for the programme budget for 2016–2017 would consider the requirements for financing from assessed contributions, based on the stewardship and governance component of the overall administrative and management costs.

The Committee noted the report.

3. COMMUNICABLE DISEASES: Item 12 of the Agenda (continued)

Global vaccine action plan: Item 12.2 of the Agenda (Document A67/12)

Ms GONÇALVES (Brazil) acknowledged the work of the Strategic Advisory Group of Experts on immunization. She outlined the successes of her country's immunization programme and underlined the key role that WHO's Expanded Programme on Immunization had played, and should continue to play, in the successful control, elimination and eradication of vaccine-preventable diseases. Despite the great progress made towards immunization targets, WHO's actions under the global vaccine action plan would remain essential for future success. All Member States should take proactive steps to improve national data quality, particularly for immunization coverage and disease surveillance. The global movement of persons and goods required Member States to continue to collaborate in order to halt the spread of disease and limit public health risks.

Ms OSPINA (Colombia) agreed with the report's assertions that low levels of immunization coverage resulting from supply shortages, difficulties reaching rural and remote areas and problems storing vaccines at the correct temperature posed a great threat to the implementation of the global vaccine action plan. The main reasons for supply shortages, however, were linked to the high costs of newer vaccines and market system failures, which impeded equitable access to vaccines. Such failures had historically been the result of limited competition between vaccine producers, a lack of innovation to produce cost-effective, thermostable vaccines in single doses, and an absence of accessible and transparent information on production costs and vaccine effectiveness. The report failed to take into account such factors in its analysis of the situation and should therefore be amended so as to reflect the full extent of the obstacles hindering equitable global vaccine access.

Dr BROU (Côte d'Ivoire) welcomed the individual progress made by Member States. A mid-term review of the national five-year expanded immunization programme identified several achievements, including the certification of elimination of maternal and neonatal tetanus and improved data management. The programme was revised in the light of the global vaccine action plan and to meet the specific challenges, including the nationwide introduction of an injectable vaccine against poliomyelitis in 2015 in the routine immunization programme and the strengthening of epidemiological surveillance. He sought continued technical support from WHO.

Mrs LAWSON-BYFIELD (Jamaica) welcomed the report, which outlined the challenges that must be tackled, and noted that smaller countries in certain regional groups, such as the Member States in the Caribbean, would be better served by one regional immunization technical advisory group, rather than several national advisory bodies. She stressed the importance of WHO's technical support and guidance to Member States in actively promulgating the achievements of the Expanded Programme on Immunization. Member States should be discouraged from providing compensation to individuals for adverse events occurring after vaccination unless documented evidence existed linking the incident to a vaccine or the Expanded Programme on Immunization. Many more resources must also be allocated to advocacy and social mobilization in order to build strong public support and confidence in immunization.

Because of the prohibitively high cost, Jamaica had been unable to purchase some of the newer vaccines, such as human papillomavirus and pneumococcal vaccines. Her country was ineligible to qualify for support from the GAVI Alliance and access to lower priced vaccines as its gross national income per capita was deemed to exceed the eligibility threshold. However, assessing eligibility in such a manner failed to reflect national debt payments, which could significantly reduce national resources available for health spending, or give sufficient weight to the burden of disease in individual countries. In order to maintain equity and social justice, she therefore called on manufacturers to offer vaccines to all countries at the same price as that offered to the GAVI Alliance and urged Member States strongly to advocate research for newer, more affordable vaccines. WHO should urge development partners to continue, and strengthen, their support for sustainable financing of the Expanded Programme on Immunization at global, regional and national levels to ensure the overall success of the global vaccine action plan.

Dr FEISUL IDZWAN MUSTAPHA (Malaysia) expressed support for the measures proposed in the report and said that his country recognized the need for data quality to be improved, particularly in regard to accurate immunization coverage. All stakeholders should also be encouraged to combat the recent growth of anti-vaccination movements through effective and far-reaching awareness-raising campaigns so that the general public had access to accurate information and could make informed decisions with regard to the risks and benefits of immunization. He therefore asked the Secretariat to provide Member States with the outcome document on anti-vaccination movements from the recent meeting of the Strategic Advisory Group of Experts on immunization at the earliest opportunity.

Dr AL HAJERI (Bahrain) welcomed the progress accomplished in eradicating poliomyelitis, reducing measles deaths and decreasing tetanus infection, and affirmed the importance of measures to strengthen surveillance systems, ensure timely and complete reporting, and validate immunization coverage data. Bahrain was committed to the Global Vaccine Action Plan and had achieved ground-breaking progress with respect to the Expanded Programme on Immunization and vaccine-preventable diseases by providing free and easy universal access to immunization services at all health centres. It was likewise committed to using tools for improving data quality on disease surveillance in general and vaccine coverage in particular.

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

4. **PROMOTING HEALTH THROUGH THE LIFE COURSE:** Item 14 of the Agenda (resumed)

Monitoring the achievement of the health-related Millennium Development Goals: Item 14.1 of the Agenda (Document A67/19)

- **Health in the post-2015 development agenda:** Item 14.1 of the Agenda (Document A67/20) (resumed from section 1)

The CHAIRMAN said that the drafting group that had been established would consider the draft resolution proposed by the 47 Member States of the African Region, which read:

The Sixty-seventh World Health Assembly,

PP1 Having considered the report on Monitoring the achievement of the health-related Millennium Development Goals. Health in the post-2015 development agenda;¹

PP2 Reaffirming the Constitution of the World Health Organization, 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 conditions;

PP3 Recognizing that health is central to human development as both a contributor and an outcome, and that universal health coverage is an important measure of development;

PP4 Recalling resolution WHA66.11 on health in the post-2015 development agenda, which urged Member States to ensure that health is central to the post-2015 UN development agenda;

PP5 Reaffirming the need to sustain current achievements and accelerate efforts in those countries where more rapid progress is needed towards achievement of the health-related Millennium Development Goals;

PP6 Acknowledging that universal health coverage implies that all people have access without discrimination to nationally determined sets of the needed promotive, preventive, curative, palliative and rehabilitative essential health services and essential, safe, affordable, effective and quality medicines, while ensuring that the use of these services does not expose the users to financial hardship;

PP7 Emphasizing that policies in sectors other than health have a significant impact on health outcomes, hence the need to identify synergies between policy objectives in the health and other sectors through a whole-of-government, whole-of-society and Health in All Policies approach the post-2015 development agenda;

PP8 Appreciating the need for countries to uphold the principles of country ownership and the global community to respect them;

PP9 Cognizant also of the burden of communicable diseases and neglected tropical diseases and the rising burden of non-communicable diseases and injuries;

PP10 Recalling resolution WHA63.16 on the WHO Global Code of Practice on the International Recruitment of Health Personnel, which recognized that addressing present and expected shortages in the health workforce is crucial to protecting global health and implementing the post-2015 development agenda,

OP1 URGES Member States:

- (1) to ensure that health remains central to the post-2015 development agenda;
- (2) to honour their commitments to meet agreed health targets and goals and to sustain and accelerate the health-related Millennium Development Goals 4, 5 and 6;

¹ Document A67/20.

- (3) to strengthen national strategies and plans for the prevention and control for the prevention and control of non-communicable diseases including injuries and Mental Disorders and Neglected Tropical Diseases;
- (4) to recognize universal health coverage as a means to ensure comprehensive health services and financial risk protection as core principle of the health component in the post-2015 development agenda;
- (5) to ensure that the post-2015 development agenda will accelerate progress towards the health-related Millennium Development Goals and reduce the burden of HIV and AIDS and other communicable diseases, as well as of non-communicable diseases;
- (6) to make the provision for the necessary elements to achieve universal health coverage, including sustainable financing, access to quality, safe and affordable health products, medicines, vaccines and diagnostics and other medical devices, and trained human resources;
- (7) to develop effective and efficient health financing systems so as raise adequate funds for health, promote risk pooling among the population prepayment for health services and strategic purchasing in order to avoid significant direct payments at the point of delivery and reduce catastrophic health care expenditure;
- (8) to adopt a multisectoral approach to address the social, environmental and economic determinants of health within sectors including, as appropriate, through the Health in All Policies approach, with a view to reducing health inequities and enabling sustainable development;
- (9) to honour their commitments towards national and international health financing in order to fully implement the post-2015 development agenda;
- (10) to ensure that external funds for specific health interventions are aligned to the national health priorities in the country by fully adhering the principles of aid effectiveness, and that they contribute in a predictable way to the sustainability of financing;
- (11) to adopt a systematic and coordinated approach to support and adequately fund research aimed at supporting the implementation of the post-2015 development agenda;
- (12) to engage actively in discussions on the post-2015 development agenda, respecting the process established by the United Nations General Assembly;
- (13) to consider the inclusion of relevant health targets and indicators under relevant sustainable development goals for the post-2015 development agenda;

OP2 REQUESTS the Director-General:

- (1) to continue active engagement with on-going discussions on the post-2015 development agenda, working with the United Nations Secretary-General, to ensure the centrality of health in all relevant processes;
- (2) to continue to provide support to countries, upon request, in articulating their positions on health in the post-2015 development agenda;
- (3) to report to the Assembly every two years on progress on the implementation of the post-2015 development agenda as it related to health.

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

5. HEALTH SYSTEMS: Item 15 of the Agenda

Regulatory system strengthening: Item 15.6 of the Agenda (Documents A67/32 and EB134/2014/REC/1, resolutions EB134.R17 and EB134.R19)

The CHAIRMAN, opening the item, said that it had been proposed to establish a drafting group on the draft resolutions. She would take it that, if she heard no objection, the Committee agreed to the establishment of the drafting group.

It was so agreed.

(For continuation of the discussion, see the summary records of the fifth meeting of Committee B.)

The meeting rose at 18:30.

FOURTH MEETING

Wednesday, 21 May 2014, at 09:40

Chairman: Professor PE THET KHIN (Myanmar)

1. SECOND REPORT OF COMMITTEE A (Document A67/64)

Dr MBUGUA (Kenya), Rapporteur, read out the draft second report of Committee A.

The report was adopted.¹

2. COMMUNICABLE DISEASES: Item 12 of the Agenda (continued)

Global vaccine action plan: Item 12.2 of the Agenda (Document A67/12) (continued from the third meeting, section 3)

Dr THANITTHA DITSUWAN (Thailand) called on her country's partners, including WHO, to focus greater attention on health system strengthening and training, managing and motivating immunization personnel. Continued support was also needed to help to strengthen national vaccine programme management, with financial sustainability and access to affordable vaccines. Potential strategies for meeting those challenges included expanding the vaccine production capacities of developing countries, strengthening national regulatory capacities, fostering mechanisms to increase vaccine availability, and increasing global and/or regional collaboration on vaccine security. The Vaccine Product Price and Procurement Project and the Global Action Plan for Influenza Vaccines were two successful projects undertaken by WHO and other partners in recent years and she encouraged the development of similar initiatives in future.

Dr AMMAR (Lebanon) said that in the light of the reported low, stagnant or even decreasing immunization coverage in many countries, increased efforts and collaboration were needed; particular attention should be given to countries experiencing conflict or political unrest. Middle-income countries that were not eligible for funding from the GAVI Alliance also faced difficulties, and could not afford some essential vaccines because of prohibitively high prices. Lebanon had been forced to increase its budget for vaccines by 20% in order to introduce inactivated polio vaccine and the shift to bivalent oral polio vaccine was hampered by its scarcity. The situation had been worsening even in countries where immunization relied to some extent on the private sector, with acute shortages of vaccines occurring. The Strategic Advisory Group of Experts on immunization had urged countries to engage with the vaccine industry in order to ensure sufficient supplies, and WHO should monitor more closely the global supply of vaccines and act to avert shortfalls.

Mr SONG Young-jo (Republic of Korea), highlighting the success of his country's national immunization programme, which was fully financed by the Government, said that the health ministry had successfully integrated information technology into the programme; all children's vaccination

¹ See page 347.

records were computerized, and his country was willing to share its experiences. Given that many Member States shared the goals of State support for new vaccines, expansion of local vaccine production and strengthening capacity for vaccine pharmacovigilance, he asked WHO to establish a committee dedicated to facilitating the implementation of the global vaccine action plan and which would encourage Member States to disclose data on the purchase costs of vaccines and adverse events following immunization.

Mr ZHANG Yong (China) said that his country prioritized immunization and actively ensured adequate funding, and training for health personnel, in that area. WHO should strengthen its technical and financial support, provide support to developing countries in using information and communication technologies, increase work efficiency, and ensure the sustainability of financing for immunization programmes. Adjusting the polio vaccination strategy should take into account the situations of different countries, particularly developing countries. It was important to analyse and manage the risks related to the adjustment and ensure the adequate supply of vaccines. For the regions that had not yet reached the targets for measles, rubella and congenital rubella syndrome, local vaccine production capacity and socioeconomic development should be taken into account when considering an extension to the deadline for reaching those targets.

Dr VALLEJO (Ecuador), recognizing the importance of political commitment and a well-structured Expanded Programme on Immunization, expressed concern at the emerging trend of limiting access to vaccines through tiered prices. Health was a right, which should be guaranteed by the State and not marketed by the pharmaceutical industry. The fact that immunization programmes helped countries to escape from the vicious circle of poverty did not mean that such countries should then be forced to pay more for vaccines. He endorsed the principles of the PAHO Revolving Fund: equity, solidarity and pan-Americanism. He advocated sustained communication with interested parties in order to respond to the needs of the people, while safeguarding the needs of the Region and respecting the principle of transparency.

Dr NGIRIGI (Burundi) said that his country had achieved its target rates for vaccination coverage. The Government was testing new communication technologies, such as text messaging, which should contribute to improved maternal and infant health and help with data management. It had developed a plan to maintain its status as having eliminated maternal and neonatal tetanus, intended to introduce inactivated polio vaccine in 2015, and had a strategic plan to eliminate measles by 2020. Surveillance of vaccine-preventable diseases needed to be strengthened in border areas and for individual cases. He accepted the recommendations of the Strategic Advisory Group of Experts on immunization.

Dr RATIH (Indonesia), welcoming the global vaccine action plan, said that monitoring, evaluation and accountability of immunization programmes would also be vital to achievement of the action plan targets. Improving the quality of data on immunization coverage and disease surveillance was a priority for Indonesia; steps being taken included web-based reporting to improve accuracy, completeness and timeliness of data. The national immunization programme had been revised and strengthened in order to meet targets such as the elimination of measles by 2020. Through high immunization coverage and high-quality surveillance, the country should also be able to achieve regional targets for the eradication of poliomyelitis and the elimination of maternal and neonatal tetanus. The Government was committed to the progressive achievement of agreed global, regional and national targets and she urged WHO and other partners to provide appropriate support to countries.

Dr OKABAYASHI (Japan) said that vaccinations contributed significantly to reducing under-5 mortality rates in particular and he welcomed the implementation of the global vaccine action plan and WHO's leadership in strengthening relevant areas of health systems. The focus on data quality was

timely and appropriate; Member States, with the support of the Secretariat, should implement the recommendations of the Strategic Advisory Group of Experts on immunization. In addition, strong political commitment and adequate government funding were needed besides the strengthening of immunization programmes in order to eradicate poliomyelitis and eliminate measles and rubella. Japan would continue to cooperate closely with developing countries and development partners in the area of immunization.

Dr DANG QUANG TAN (Viet Nam) said that his country had increased vaccination coverage and was improving self-sufficiency in vaccine production. It faced, however, a significant challenge: upholding public trust in the immunization programme. New ways had to be found to raise public awareness of the benefits of vaccination and create demand at community level.

Countries continued to face challenges in meeting the cost of vaccines and evaluating the evidence on their safety, efficacy and effectiveness. He called on the Secretariat to help Member States to strengthen their capacity for assessing the cost-effectiveness of vaccines and to sustain their immunization programmes in line with their needs and priorities.

Mrs SMIRNOVA (Russian Federation) underlined the necessity of collection and analysis of high-quality data on immunization coverage and disease surveillance for the proper and effective management of national immunization plans. There was also a need to introduce modern information and communication technologies, increase vaccine coverage rates, detect and overcome barriers to vaccination, ensure reliable oversight, and increase investment in those areas. Coordinated action on poliomyelitis eradication and elimination of measles and rubella should be a priority for all countries. Serological monitoring and catch-up vaccination activities against measles and rubella had been undertaken, even in hard-to-reach communities. Her Government had recently increased its investment in immunization, enabling it to include pneumococcal vaccine in the routine immunization programme for young children. It also contributed to strengthen surveillance of vaccine-preventable diseases internationally, particularly in countries of the Commonwealth of Independent States, and had allocated funds to strengthen their national laboratory systems and improve training of staff.

Dr AL-TAAE (Iraq), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that governmental ownership of, and commitment to improving, countries' immunization programmes were the cornerstone of their success. Governments needed to ensure that those programmes included adequate indicators and goals, were sufficiently staffed, took account of epidemiological and demographic variables, and were reliably monitored and evaluated. Attention should also be given to ameliorating institutional governance. The main challenge for middle-income countries was the cost of new vaccines; increased support was needed from partners in that regard. Vaccine manufacturers should be engaged in order to ensure the availability of inactivated polio vaccine at a price that middle-income countries could afford. More support was needed from partners for implementing national plans for the elimination of measles and neonatal tetanus and to combat the re-emergence of poliomyelitis. New technologies for improving vaccination coverage and data quality, as well as timely reporting by neighbouring countries, would make a crucial contribution. Technical work should focus on genotyping of pathogens and antigenic drift. He called for increased support from WHO.

Mr MACHARIA (Kenya), speaking on behalf of the Member States of the African Region, said that many countries in the African Region lacked adequate data as the diverse terrain, lack of adequate resources and armed conflict in some countries made data collection difficult. He called on national governments, development partners and international agencies to provide support for improving data quality. Partners should work with developing countries to establish a bottom-up, step-by-step, country-specific approach and provide guidance on coverage and surveillance data validation.

Despite significant reductions in mortality and morbidity from vaccine-preventable diseases in the Region, there continued to be high immunization dropout rates, with considerable disparities

within countries. In addition, inadequate resources for routine immunization, resistance to immunization by some social groups, low coverage rates in remote areas and the internal and cross-border displacement of persons were challenges that restricted countries' abilities to achieve their vaccination targets and the health-related Millennium Development Goals as a whole. Stakeholders should redouble efforts to strengthen national health systems and immunization programmes, particularly as the world was close to seeing the fruition of its poliomyelitis eradication efforts. He encouraged all countries to establish technical advisory groups or similar mechanisms for making immunization-related policy recommendations; technical agencies and development partners should provide capacity-building support.

Mrs NAARENDORP (Suriname), speaking on behalf of the Union of South American Nations, highlighted the contribution of the PAHO Revolving Fund to progress towards attaining Millennium Development Goal 4 through vaccination; it enabled countries to obtain access to a continuous supply of high-quality vaccines at the lowest available price. As a result, the regional immunization coverage rate was 95%. The Fund, based on the principles of pan-Americanism, equity and quality, could serve as a model for other regional and global strategies.

The introduction of new vaccines should be based on convincing scientific evidence. The Secretariat should work with Member States in: implementing an information system that provided real-time data on vaccination coverage and monitoring of vaccine-preventable diseases; maintaining coverage above or equal to 95%; continuing monitoring to ensure the sustainability of the elimination of diseases such as measles, rubella and congenital rubella syndrome and maintain the eradication of poliomyelitis; strengthening universal access and mitigating geographical barriers to vaccination access; and promoting the introduction of new vaccines based on evidence of benefits and cost-effectiveness.

Professor ELIRA DOKEKIAS (Congo) said that the availability of vaccines had enabled several African countries to achieve, or almost achieve, health-related Millennium Development Goals. The global vaccine action plan identified the challenges to be overcome, but certain weaknesses needed to be tackled first, including anti-vaccination campaigns in some countries that posed a threat to their neighbours because of the risk, for example, of imported poliovirus, and vaccination coverage rates that were insufficient for achieving measles elimination. In 10% to 15% of children, vaccination did not necessarily confer immunity. New vaccines, in particular, against pneumonia, rotavirus and human papillomavirus infections, were expensive and inaccessible; several African countries that currently received support from the GAVI Alliance would no longer be eligible after 2015 and would have to meet the costs themselves. It was important not to let slip the gains made in vaccination coverage in Africa. Ways needed to be found, for example, to improve protection against cervical cancer through immunization, particularly among young adolescents, and to strengthen research into new vaccines, against for instance hepatitis C, of particular concern for Africa.

Dr AL JARDANIYA (Oman) commended the progress achieved by the Organization through the global vaccine action plan, agreeing that vaccines and immunization had created a healthier world. The Sultanate was remained committed to the strategic objectives of the action plan, and would lend the support needed for its adoption and implementation. It was striving to achieve the highest levels of immunization and appealed for continued efforts and increased investment with a view to attainment of the Decade of Vaccines' goals of disease eradication or elimination and reduction of mortality and morbidity from vaccine-preventable diseases.

Ms GIMÉNEZ MAROTO (Spain) said that immunization programmes were a basic public health strategy and a priority area for Spain in terms of cooperation with other countries. In order for national immunization programmes to be consistent, it was crucial to strengthen health systems and provide sufficient funding. Moreover, the immunization programmes should be linked to efforts to achieve Millennium Development Goal 4 and other public health interventions. Spain had a free and

universal vaccination programme for all its citizens and contributed to the achievement of the targets set out in the global vaccine action plan through its financial contributions to the GAVI Alliance. In addition, it used bilateral cooperation mechanisms for direct vaccine purchases and to reach defined geographical areas.

Dr GNASSINGBÉ (Togo) said that, despite the significant increases in vaccination coverage and consequent reductions in morbidity and mortality, challenges remained – particularly for countries afflicted by conflict. He welcomed the support received from the international community for the introduction of new vaccines in Member States in the African Region and the recommendations of the Strategic Advisory Group of Experts on immunization regarding data quality, vaccination coverage, eradication and elimination efforts, and ownership of national immunization programmes. He also highlighted the progress made in Togo on immunization, particularly with regard to reducing the morbidity and mortality rates of vaccine-preventable diseases among women and children; the programme had great impact and served as a tool for integration.

Mr RUIZ MATUS (Mexico) said that immunization programmes should be considered a public good and be maintained. Increasing vaccination coverage, particularly in children under the age of one year, should be a top priority for all countries, and new tools should be used to accelerate the reduction of the burden imposed on society by vaccine-preventable diseases. He urged the Secretariat to strengthen its support for technology transfer to countries facing the threat of poliomyelitis in order to increase the production of inactivated poliovirus vaccine. In addition, Member States should redouble their efforts to eliminate measles, rubella and congenital rubella syndrome, guarantee the containment of outbreaks of those diseases and prevent them spreading to other countries that had already eradicated them, such as those of the Americas.

Ms THATANNE (Namibia) highlighted the measures undertaken in her country with the support of development partners to implement the global vaccine action plan: vaccination coverage was almost universal and the cold chain had been upgraded in preparation for the introduction of pneumococcal and rotavirus vaccines in 2014. Proper assessment of disease burden and technical, logistic, managerial capacity, together with a risk–benefit analysis and planning for sustainability were needed when considering the introduction of new vaccines. Namibia was fully committed to achieving the strategic objectives of the global vaccine action plan, but they could be achieved only in an ideal world where countries enjoyed access to all the necessary resources. In addition, the requirement for countries to report on their national immunization expenditure presented various problems for Namibia, as the immunization programme was integrated with other primary health care interventions, thereby making it difficult to establish per-person expenditure rates. Health systems strengthening and logistical and technical support were needed if the objectives were to be met.

Ms IBRAHIM (Maldives) said that the global vaccine action plan was an important strategic document that would help Member States to achieve the goals of the Decade of Vaccines, but she expressed the hope that it would facilitate the monitoring of availability and accessibility of vaccines and their costs. Further progress required a balanced approach that acknowledged the challenges faced and included tangible solutions. Timely and accurate data on immunization coverage and disease surveillance were crucial to decision-making processes. The key challenge faced by Maldives, where the coverage rate was more than 95%, was vaccine procurement; the country depended entirely upon imports for its vaccine supply. Rising costs and restricted availability and accessibility posed a significant threat to the implementation of the country's immunization programme, together with high wastage, distribution difficulties and out-of-stock events – hindrances that were shared by other small countries in the South-East Asia Region. She called for greater regional collaboration to develop economies of scale in the purchase of vaccines and managing immunization programmes. Maldives' graduation from least-developed country status had occurred without due consideration of the

challenges and meant that it was struggling to access available support. She lamented the activities of anti-vaccine groups.

Dr LAHLOU (Morocco) said that Morocco attached great importance to immunization, for which funding was guaranteed from the Government's general budget. Immunization coverage was currently 98% and new vaccines, including rotavirus and pneumococcal vaccines, had been introduced into the national programme in 2010. Immunization had contributed significantly to reducing child and infant mortality; deaths due to tetanus had fallen by 95% and measles by 84%. Measles and rubella eradication campaigns had been conducted in 2008 and 2013, and second doses of both vaccines had been introduced in early 2014.

In order to achieve agreed targets, countries such as Morocco required technical and logistical support from partners including WHO, for instance for evaluation of programme implementation and dissemination of the findings; sharing of the benefits of successful immunization exercises undertaken in developed countries; establishment of clear and transparent monitoring of the entire vaccine production process; and the development of mechanisms for identifying potential obstacles to immunization programmes, notably vaccine pricing, which frequently prevented countries from putting WHO's recommendations and scientific developments into practice. Coordinated international efforts were essential to ensuring sustainable financing for national immunization programmes, which called for cost-control mechanisms to benefit countries currently disadvantaged in the area of vaccine procurement, among them Morocco.

Dr Y. PILLAY (South Africa) said that more needed to be done to strengthen the capacity of countries and regions to produce vaccines and thus ensure supply, particularly with regard to older vaccines whose low profitability meant little incentive for production and the limited number of whose manufacturers raised the risk of stockouts. Moreover, the costs of newer vaccines continued to be prohibitively high for many developing countries; South Africa had recently introduced pneumococcal, rotavirus and human papillomavirus vaccines at significant expense and demanding large resources. The Secretariat and WHO's partners should cooperate with countries and regions to reduce prices. To complete implementation of the action plan, Member States and the international community should increase investments in the Expanded Programme on Immunization.

Ms CHAMMAS (Germany) acknowledged the highlighting in the report of the importance of data quality improvement. She noted that the GAVI Alliance's second replenishment cycle for the period 2016–2020 had begun the previous day. That body's work was exceptional, having facilitated the vaccination of some 440 million additional children since its establishment in 2000 and reduced the cost of vaccinations in partner countries by 90%. Nevertheless, many of the 6.6 million deaths of children under five years old in 2012 were due to preventable or curable diseases. It was unlikely that the targets for Millennium Development Goals 4 and 5 would be met. She therefore supported the Alliance's goal of vaccinating another 300 million children by 2020, urging the creation of the necessary conditions and the mobilization of the resources required to reduce child mortality in a comprehensive and sustainable manner. She reiterated her Government's recent offer to host the Alliance's replenishment meeting.

Ms SOVD TUGSDELGER (Mongolia), recalling her country's status as polio- and measles-free, said that it still faced challenges. As the rates of vaccine-preventable diseases declined, anti-vaccination groups had become more vocal; in consequence, surveillance and risk communication of post-immunization adverse events should be strengthened nationally and globally. She supported the recommendation to improve the quality of data on immunization programmes and expenditure, given that discrepancies in the data recorded on vital events in developing countries often portrayed a more positive outlook than was warranted in reality. In Mongolia, immunization rates related only to people registered with health services, and population-based surveys had revealed lower coverage. It was therefore important to strengthen health information systems and health accounts, and she called on

WHO to renew its commitment to increasing the visibility of civil registration and vital statistics systems and National Health Accounts within the public health agenda.

Mr MESBAH (Algeria) noted that implementation of the global vaccine action plan would require introduction of new vaccines, more comprehensive planning, better data collection on immunization coverage and monitoring of vaccine-preventable diseases, and equitable access to universal vaccination programmes. Speaking from the point of view of a middle-income country with an immunization programme that had recently introduced four new vaccines, he drew the Committee's attention to the high cost of new vaccines, which risked compromising the progress made and would prevent the full implementation of the action plan. He called on WHO to support the establishment of a joint purchasing mechanism for middle-income countries and local production of vaccines through partnerships, in those countries that possessed the appropriate capacity.

Dr GOUYA (Islamic Republic of Iran) said that, although epidemiological data and improvements to data quality were undoubtedly important, surveillance of vaccine-preventable diseases could be improved through laboratory-based studies and the application of their results at national level. WHO should further support capacity-building in national laboratories, and promote the development of subregional or regional laboratories. Increasing coverage, especially in suburbs and marginalized areas of large urban settings, would ensure improved immunization coverage. The national Expanded Programme on Immunization had incorporated monitoring and reduced coverage gaps in certain population areas. The timing of the introduction of an additional dose of inactivated poliovirus vaccine into the routine immunization programme needed further study, and he urged that the proposed deadline be reviewed.

Dr REDDY (India) endorsed the recommendations in the report. He observed that the Universal Immunization Program in India, 2012–2017, corresponded to the global vaccine action plan and that the country's national vaccine policy shared many of the latter's recommendations. His country had introduced a web-based health management information system in order to improve its national immunization coverage and disease surveillance data. Action to improve routine vaccination coverage was being focused on poorly-performing states and districts identified through polio eradication efforts. The country continued to make steady progress towards the elimination of maternal and neonatal tetanus and aimed to eliminate measles by 2020. India had reinforced its regulatory capacity, including institutions responsible for immunization, and would continue to deal with some of the strategic gaps identified in the action plan, including shortcomings in disease surveillance. He thanked WHO and other partners for their ongoing technical support in strengthening universal vaccine access in India.

Dr EL-REFAY (Egypt) said that his country was highly committed to the global vaccine action plan, particularly with regard to the improvement of data quality, effective surveillance, mandatory vaccination coverage and capacity-building for the national immunization programme. It had achieved the programme targets, which were consistent with WHO's indicators, and coverage for mandatory vaccinations ranged from 96% to 98%. Many challenges remained, however, as certain vaccines were costly and difficult to obtain for low- and middle-income countries such as Egypt. He therefore appealed to WHO to endorse the request for the GAVI Alliance to review the support mechanism for those countries or to work on an initiative to facilitate access to affordable vaccines, especially the pentavalent vaccine, rotavirus vaccine and inactivated poliovirus vaccine, in order to attain the appropriate health improvement targets.

Mr BOYCE (Barbados), speaking on behalf of the member countries of the Caribbean Community and expressing support for improving immunization coverage and disease surveillance data quality as part of ongoing efforts to promote the introduction of new vaccines and ensure the sustainability of the existing Expanded Programme on Immunization, stressed the need for resources

to support countries in the collection of such data. In the light of growing levels of misinformation from anti-vaccination movements, he called on the Secretariat to devise proactive strategies to increase vaccine acceptance among the general population including, where appropriate, the use of online social media. He underscored the risks surrounding the re-emergence of certain vaccine-preventable diseases and requested the Organization's technical and financial support to countries of the Caribbean Community as they sought to establish successful vaccine awareness-raising and confidence-building strategies. He called on WHO to work towards lowered costs of new vaccines needed to meet the global immunization targets, and to take further action to promote equitable access to such vaccines.

Dr SANON (Burkina Faso) extolled the progress Member States had made in introducing effective immunization programmes to reduce infant mortality linked to vaccine-preventable disease. Her country had eliminated maternal and neonatal tetanus in 2012 and had recorded no new case of poliomyelitis since 2009 or of meningococcal meningitis since 2011. Looking ahead, she stressed the importance of improving vaccine storage and transport, targeting population groups other than children as part of national immunization programmes, and lowering the high costs of new vaccines – her Government had allocated funding for the purchase of new vaccines, but at existing prices that funding was not sustainable. She therefore called on WHO to advocate with development partners the lowering of the cost of vaccines for countries with limited resources.

Dr TARAWNEH (Jordan) said that improvement in the quality of data on immunization coverage was particularly important. Jordan had been among the first countries in the Middle East to introduce vaccines as part of a national programme; coverage currently approached 98%. It had been free of polio, neonatal tetanus and diphtheria for many years. It had been on track to eradicate measles until cases had emerged among Syrian refugees in 2013. Despite its limited financial resources, it had mounted three national polio and measles immunization campaigns, as recommended by WHO. The Government was committed to the immunization of refugees crossing into its territory and was strengthening its national surveillance system, especially in refugee camps. He called on international organizations to intensify their support to low- and middle-income countries, particularly those in conflict areas, by increasing their access to vaccines, including the more costly ones, in order to preserve the gains achieved in immunization.

Dr GÓLCHEER-VALVERDE (Costa Rica) said that his country had introduced a new health management information system to track immunization coverage more closely and collect more reliable and accurate disease surveillance data. Each quarter, the Government analysed coverage data to support decision-making; national coverage rates were currently around 95%. It had also recently established a new strategy to accelerate the elimination of measles, rubella and congenital rubella syndrome with support from PAHO through its Revolving Fund. He urged the Secretariat and Member States to continue their efforts to implement the global vaccine action plan and confirmed his country's willingness to share knowledge and information.

Dr SUHAIL (United Arab Emirates) said that the global vaccine action plan had clearly given impetus to national immunization programmes and the improvement of vaccine coverage rates. Periodic reviews and evaluations were essential, as was an effective system for monitoring optimal use of data analysis and assessment technologies, enabling all countries to identify potential obstacles to achievement of the planned targets. To that end, Member States had been urged to report to their respective regional committees on progress made and challenges remaining in their national immunization programmes and to monitor immunization activities, progress and achievements during the Decade of Vaccines. She reaffirmed her country's commitment to continued reviewing, developing and updating of its national immunization strategies. It would also pursue cooperation in the area of capacity-building for health workers and continue to raise public health awareness with a view to facilitating access to immunization for all. It constantly benefited from WHO guidelines to improve all national programmes, in particular the national immunization programme.

Ms P. GONZÁLEZ (Uruguay) noted the efforts made in the Region of the Americas to provide protection against vaccine-preventable disease, in particular for children. Her country provided mandatory, universal and free access to numerous vaccines and had an immunization coverage greater than 95%. The Government planned to take further steps to target remote and rural areas where immunization coverage remained lower than the national average as part of efforts to increase national vaccine access, and had introduced a national vaccination awareness-raising week. She acknowledged the indispensable support of PAHO's Revolving Fund, which was a model for supporting the realization of the global vaccine action plan. She stressed that a vaccine access policy must adopt the principles of solidarity, universality and equitable access.

Dr BEN SALAH (Tunisia) stated that Tunisia had recorded no case of poliomyelitis in the past 20 years and had eliminated maternal and neonatal tetanus. The Government was currently examining the case for introducing new vaccines into the national immunization programme. He called on WHO to support joint initiatives between low- and middle-income countries to permit countries with fewer resources to obtain their vaccines through bulk purchasing and strengthen their immunization programmes. He also called on WHO to review the advisability of harmonizing the list of recommended vaccines for target populations other than children, such as health care professionals and persons with chronic diseases.

Ms ROWE (United States of America) fully supported the report's focus on the importance of Member States' political commitment at all administrative levels to collecting accurate immunization coverage and disease surveillance data, stressing the need to monitor global supplies and pricing in order to safeguard equitable access to vaccines. Some indicators and targets in the global vaccine action plan's Accountability Framework required further definition and clarity, with information on how countries would use the results of the Framework and how regional committees' recommendations would be implemented in practice. The Framework could also usefully incorporate a global dashboard for monitoring national progress against key global indicators. The Secretariat should be more ambitious when formulating targets for developing and introducing new, improved and underutilized vaccines and technologies by 2020, and further attention should be paid to issues of vaccine costs, delivery and affordability. Underlining collaboration and programmatic coordination, she urged Member States to continue to support the greater use of the influenza vaccine and the introduction of new vaccines, such as pneumococcal, rotavirus and meningococcal vaccines.

Mr ELIAS (Ethiopia) agreed that reliable immunization coverage and disease surveillance data were crucial for proper management of national immunization programmes. All concerned parties should undertake data quality improvement initiatives, with special emphasis on enhancing national health management information systems, rather than on immunization data alone. The recommendations of the Strategic Advisory Group of Experts on immunization concerning data quality improvement should be put into practice. New technologies for expanding and monitoring best practices between countries and regions should also be strengthened. His country, along with the other countries of the African Region, would continue to work towards measles, rubella and congenital rubella syndrome elimination and intended to reach 95% measles vaccine coverage by 2020.

Dr SUNDARANEEDI (Trinidad and Tobago) welcomed the progress that had been made towards disease eradication and the decreases in mortality and morbidity, particularly through the introduction of new vaccines. The global vaccine action plan had proved valuable to countries such as his own in developing national frameworks for disease elimination. His Government was committed to using strategies to eradicate vaccine-preventable diseases that were in keeping with the principles of the action plan. It had improved the quality of data collection to ensure better management of immunization programmes and thus progress towards meeting immunization targets and disease reduction. It aimed to increase the overall national immunization coverage rate from more than 90% to

95% or above by 2015. It had introduced human papillomavirus vaccine and was drafting an action plan for introducing at least one dose of inactivated poliovirus vaccine.

Dr MODESTE-CURWEN (Grenada) said that, thanks to the PAHO Revolving Fund for Vaccine Procurement, beneficiary States had seen dramatic progress in reducing morbidity and mortality from vaccine-preventable diseases in the past three decades. In the Caribbean, immunization was seen as an important investment in health, but there were fears over the potentially dire consequences if the cost of vaccinating children became prohibitive. It was vital that vaccines were affordable and available to all; access to vaccines was fundamental in achieving universal coverage. She endorsed the calls by other speakers for the prices of vaccines to be lowered to reasonable levels.

Mr ABDULLAYEV (Azerbaijan) said that overcoming and eliminating vaccine-preventable diseases such as measles and poliomyelitis needed to remain a priority for WHO. A single, comprehensive approach was needed for prevention and immunization; success would be possible only through robust decisions and adequate disease monitoring and surveillance.

Immunization programmes needed to be strengthened globally through the introduction of new vaccines, improved regulatory standards and increased capacity. WHO should act as the primary point of coordination between countries and donors. Every effort was needed to ensure that all children were protected against those preventable diseases.

Dr KABULUZI (Malawi), noting that vaccines were essential interventions that prevented many diseases, welcomed the efforts made globally to ensure that children were vaccinated. With support from the GAVI Alliance, Malawi had been able to introduce several new vaccines in recent years.

Dr SMEU (Libya) said that Libya was free of poliomyelitis and tetanus and was currently working on the earliest possible eradication of measles and rubella. Several new vaccines had been introduced into its national immunization programme, including rotavirus, pneumococcal and human papillomavirus vaccines. Inactivated poliovirus vaccine was being administered as part of a hexavalent vaccine. An immunization programme was also being developed for adults, the elderly and high-risk groups. A mechanism for ensuring affordable access to vaccines was crucial, however, given the limited resources of low- and middle-income countries. It was also essential to increase vaccine types and introduce new vaccines into national immunization programmes, although that weighed heavily on the relevant budgets.

Dr VIZZOTI (Argentina) said that Argentina's free and obligatory immunization programme had had a considerable impact over the past decade. The national immunization programme covered 16 vaccines, including those against hepatitis A and B, pneumococcal infection and human papillomavirus infection. A national system to support the control of vaccine-preventable diseases had been established, which provided real-time information on the vaccination status of individuals. The system helped to ensure vaccination coverage at both the provincial and national levels. The country had also had no reported cases of measles, diphtheria, neonatal tetanus or rubella for several years.

She welcomed the reduction in morbidity and mortality globally as a result of the introduction of new vaccines in the national programmes of low- and middle-income countries. However, the challenge was to sustain the achievements made; due attention needed to be given to the risk of diseases being imported into countries that had already reached elimination or control targets, such as Argentina. All States needed to apply systems for early warning, detection and prevention in order to minimize the threat. All governments and relevant international organs needed to ensure that there was appropriate investment in vaccinations in order to achieve the targets set for the Decade of Vaccines and to protect people from preventable diseases.

Dr RASHID (United Republic of Tanzania) said that her country continued to prioritize immunization and had been able to sustain a coverage rate of more than 90%, above the target set in the global vaccine action plan. Rotavirus and pneumococcal vaccines had been introduced, and the extension of the range of vaccines was significantly improving child survival. In recent years, the country had achieved polio-free status, eliminated neonatal tetanus and established measles case-based surveillance. However, the consistent rise in the price of vaccines was of concern.

Dr Chang-Hsun CHEN (Chinese Taipei) said that Chinese Taipei used electronic systems to collect people's immunization records and carry out disease surveillance. Catch-up services were provided for missed vaccinations. Seroprevalence data were used to help to audit and ensure high immunization coverage.

Instabilities in the supply of composite vaccines, as had repeatedly occurred, threatened the achievement of high coverage of diphtheria, tetanus and pertussis-containing vaccines, one of the core components of the global vaccine action plan. He urged all stakeholders and manufacturers to commit themselves to stabilizing the vaccine supply in order to ensure effective global disease prevention.

Ms KUSYNOVÁ (International Pharmaceutical Federation), speaking at the invitation of the CHAIRMAN, welcomed the emphasis by WHO on the need to use pharmacists to their full potential in educating people on the safety and relevance of immunization and for facilitating or providing vaccination. Confidence in the safety of vaccines needed to be supported by proper vaccine vigilance and secure supply-chain management. Vaccines needed to be safe and available, but they also needed to be accepted by communities and administered; there was growing evidence that pharmacists were able to improve vaccine coverage among target groups that other health care professionals found harder to reach.

Ms ELDER (MSF International), speaking at the invitation of the CHAIRMAN, said that, currently, the only data systematically available on the cost of vaccines were those covering the prices paid by the PAHO Revolving Fund and UNICEF for vaccines supported by the GAVI Alliance. It was otherwise unclear what most countries paid for vaccines and, two years after the adoption of the global vaccine action plan, serious concerns remained about the lack of vaccine affordability. Greater efforts were needed to ensure improved affordability. According to publicly-available information, the cost of fully vaccinating a child had risen by 2700% in the past decade. It was essential, therefore, that prices be monitored, especially for countries that would become ineligible for support from the GAVI Alliance and middle-income countries that increasingly could not afford the high costs. It was a paradox that, because of the prices, middle-income countries were introducing new vaccines at a slower rate than the poorest countries that received support of the GAVI Alliance.

She urged all Member States to help the secretariat of the action plan to obtain a comprehensive picture of the global vaccine market by reporting each year on the prices paid by the public sector for vaccines and by gathering information on prices in self-procuring middle- and high-income countries and the private sector.

Ms EVANS (GAVI Alliance), speaking at the invitation of the CHAIRMAN, said that country demand for vaccines and vaccine introductions supported by the GAVI Alliance had reached an unprecedented level in 2013, which meant that further dramatic declines in child mortality were possible ahead of the date set for achieving the Millennium Development Goals. In recent years there had been increased demand in particular for pneumococcal, rotavirus, pentavalent, human papillomavirus and inactivated poliovirus vaccines. The dramatic acceleration and scaling up of the introduction of 11 vaccines supported by her organization had resulted in 440 million children being immunized, equivalent to six million lives saved.

A country-driven approach and high-level political commitment were essential to improving vaccine coverage. The GAVI Alliance also fully supported the focus given to improved data in the

global vaccine action plan and endorsed the emphasis in the progress report on that issue; good data were vital for finding the one child in five who remained unimmunized.

Countries that were graduating beyond support from the Alliance often raised concerns over how they would sustain their immunization programmes. It was essential that they be able to purchase vaccines at affordable prices, and all partners needed to work on developing proposals for pooled procurement facilities. The Alliance had the previous day launched its replenishment drive for 2016–2020, and she urged all partners to work to ensure a fully funded GAVI Alliance as part of collective efforts to achieve the goals set forth in the global vaccine action plan.

Dr AYLWARD (Assistant Director-General) welcomed the many comments made on the first assessment of the global vaccine action plan, several of which had reaffirmed the good progress being made in global immunization, including investment therein, and had confirmed that the action plan was moving in the right direction and following the right vision. However, there was also evidence of a slow translation of commitment into action for improved coverage, with 130 countries not on track to achieve the critical goal of at least 90% immunization coverage nationally and 80% in every district. The goal was essential not only to the action plan but also to the Millennium Development Goals.

The Secretariat appreciated that data quality was the foundation of good immunization coverage and future strengthening of programmes and accountability for immunization at all levels. The Organization took note of the need to look at electronic tools and innovative technologies that could be of value, especially within national health-system contexts, and was committed to and already investing in appropriate standards, tools and best practices. He had also taken particular note of the concerns raised regarding measles and the need to redouble efforts to ensure that efforts to achieve the goal of measles elimination were put back on track.

He noted the concerns over vaccine logistics, access, security and pricing, underscoring that, with data quality, those were the greatest areas of growth in the Organization's work on vaccines. In order to improve cold-chain capacity, WHO and its partners had introduced a comprehensive, effective management approach for vaccines and, regarding the issue of pricing, collaboration among WHO, UNICEF, the GAVI Alliance, PAHO, MSF International and the Bill & Melinda Gates Foundation had resulted in the publication of the first annual report on vaccine pricing, which had been available online since February 2014. WHO would also soon be launching a vaccine product pricing and procurement project, which would provide reliable, accurate and objective information on pricing on a sustainable basis.

The Organization and its partners were currently in talks with several potential producers in Africa on how to improve both vaccine security and manufacturing capacity across the continent, including the regulatory frameworks that were needed to ensure the quality supply of safe vaccines. Although it was good news that new vaccines were coming onto the market, it was clear that greater attention needed to be given to the issue of access and affordability in middle-income countries. WHO was making efforts to understand better the needs and challenges of such countries, for instance through work on market intelligence, transparency on pricing and new pool procurement mechanisms. In the light of the remarks made specifically about inactivated poliovirus vaccine, given the accelerated timelines for its introduction and the need for its full use globally, the Secretariat was advancing some of the steps it intended to take to support middle-income countries in that area. A task force was also due to be established that would look at the particular issues experienced by middle-income countries and its findings could be reported to the Sixty-eighth World Health Assembly. In response to the comments about the importance of maintaining public trust in vaccines, he noted that the first report on the issue by a working group of the Strategic Advisory Group of Experts on immunization, which would be submitted in the third quarter of 2014, would serve as the basis for a full programme of work in that area.

The Committee noted the report.

Hepatitis: Item 12.3 of the Agenda (Documents A67/13, A67/13 Add.1 and EB134/2014/REC/1, resolution EB134.R18)

Dr FRANCIS (Bahamas) noted the devastating consequences of viral hepatitis on global health: most people with chronic hepatitis were asymptomatic and unaware that they were infected. He supported the draft resolution contained in resolution EB134.R18 but had reservations regarding the costs associated with implementing the strategies outlined. Low- and middle-income countries faced challenges in their capacity to ensure the necessary screening, diagnosis and treatment; it would therefore be important to establish appropriate surveillance mechanisms, which would require significant financial support. Cost should not exclude patients' access to treatment; that would threaten the sustainability of the initiative. He urged WHO to apply strategies that would improve capacities for implementing cost-effective and sustainable surveillance programmes.

Ms BRAN (Guatemala) said that the draft resolution effectively reflected the actions that were necessary for the prevention, diagnosis and treatment of viral hepatitis and that Guatemala wished to be added to the list of sponsors of it. The country had developed guidelines on preventing water- and food-borne diseases, launched campaigns on safe drinking water and established a surveillance system for monitoring and reporting on hepatitis A, as well as outbreak control. Guatemala had also established educational and preventive programmes for the general population on sexually transmitted infections, including those with hepatitis B virus, and hepatitis C, and continued to undertake the necessary efforts to provide technical support and develop national strategies for prevention, diagnosis and treatment.

Dr LATIF (Afghanistan) said that chronic hepatitis B was a significant public health problem in Afghanistan with high morbidity and mortality. Nevertheless, good progress had been made in immunizing children since the introduction of hepatitis B vaccine into the routine immunization programme in 2006 and the birth dose in 2013. Diagnosis and management of the virus remained complex, and he called for greater human resource development and awareness-raising among the public, especially in developing countries. He supported the draft resolution.

Dr KAZIHISE (Burundi), speaking on behalf of the Member States of the African Region, welcomed the draft resolution and urged all countries to ensure that all newborn infants were vaccinated against hepatitis B. Despite the work of the Global Hepatitis Programme, the disease remained under-recognized globally, with many cases of infection remaining undiagnosed, especially in Africa.

He noted with interest the development of new medicines to treat hepatitis C, but remained concerned that the exorbitant prices and lack of availability in Africa prevented access to treatment for many patients. He therefore urged the Secretariat to support national decision-makers by ensuring the provision of up-to-date, scientifically verifiable epidemiological data nationally and regionally. It should also collaborate with Member States to facilitate the establishment of national programmes for raising public awareness and promoting testing, prevention and greater vaccine coverage. The Secretariat also had a key role to play in improving the availability and affordability of medicines and in providing formal support to Member States in price negotiations.

Dr AMMAR (Lebanon) welcomed the responses proposed in the report to the challenges of combating chronic viral hepatitis, including the unaffordability of new treatments in low- and middle-income countries. The Secretariat's support was required, in particular in developing guidelines for testing and treatment and also for prequalification of laboratory kits and pharmaceutical products. WHO's regional offices should take on a central role regarding price negotiation and pooled procurement of vaccines and medicines, and in building capacity to that end.

Despite the issues of affordability and availability, Member States should not forget that prevention remained the cornerstone of national strategies to fight hepatitis. Health authorities needed

to ensure that people were not infected as a result of unsafe practices. As a sponsor of the draft resolution, Lebanon urged its adoption.

Dr ZHOU Jun (China) commended the Secretariat's support in the prevention and control of viral hepatitis, especially for people living with HIV who were coinfecting with hepatitis B or C virus. China carried out regular epidemiological surveys and had taken comprehensive control measures, and had already achieved the targets set for hepatitis B prevention and control.

He supported the draft resolution and called upon all stakeholders to increase financial and technical support to developing countries with a high burden of viral hepatitis. More support was also needed for research and development of antiviral medicines and in coordinating with manufacturers to reduce their prices.

Ms KIPIANI (Georgia) expressed support for the draft resolution and asked for Georgia to be added to the list of sponsors.

Dr AL-TAAE (Iraq) supported the draft resolution. Greater attention should be paid to food safety and preventing and controlling food- and water-borne diseases, such as hepatitis A and E. Hepatitis B and C were evolving and more attention needed to be given to eliminating health care practices that led to their transmission through well-designed infection control procedures, including training of health personnel and drafting of legislation to prevent actions that risked transmission. Further preventive action included adequate communication and awareness-raising among the public as well as social mobilization. The safety of the blood supply had been secured in Iraq. Hepatitis B vaccination had been part of the national Expanded Programme on Immunization for more than 20 years and was also administered to people at risk of infection. A primary health care focus based on evidence-based practices was essential and should cover sexually transmitted infections, with premarital examination and linkage with reproductive health and maternal and child health programmes. The health ministry had established a high-level committee on prevention and control, including early detection and management of chronic hepatitis and hepatocellular carcinoma. Laboratory procedures for early diagnosis and follow-up of cases needed improvement. Immigrant workers were tested for hepatitis B and C, and the data recorded in their health certificates.

Dr SHIMIZU (Japan) supported more comprehensive measures for dealing with chronic hepatitis, from early diagnosis to appropriate medical care on a global scale, as part of wider efforts to tackle noncommunicable diseases. Access to medicines for treating hepatitis was not the only barrier to the global promotion of prevention and control; human resource development, the development of adequate medical infrastructure at all levels, and the collection of scientific evidence on the treatment of hepatitis were particularly important.

Dr ABDELNASSER (Egypt), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that viral hepatitis needed to be made a high global priority in order to strengthen responses for prevention, diagnosis and treatment and to reduce the costs of new medicines and producing vaccines. All hepatitis viruses were present in the Region. Hepatitis C was a particular problem, with 17 million people infected with the virus and 800 000 new cases reported each year; Egypt and Pakistan had the highest rates of hepatitis C virus infection in the world. The prevalence rate of chronic hepatitis B virus infection ranged from between 2% and 3% in some countries in the Region to between 7% and 10% in others: altogether some 4.3 million people became infected every year.

The Region encountered many of the challenges that had been outlined in the report, not least a lack of access to new treatments at affordable prices. Further research was needed on prevention, diagnosis and treatment. International organizations, financial institutions and relevant stakeholders had to be actively engaged in order to build capacity in developing countries for increasing the use of reliable diagnostic and treatment methods suitable to local epidemiological situations and in order to

assign resources for the prevention and control of viral hepatitis. The necessary technical support must also be provided to countries in an equitable and suitable manner, with improved access to affordable treatment in developing countries.

He commended the recent WHO Global Partners' Meeting on Hepatitis, which had sought to advance the global responses to viral hepatitis, and urged all Member States to adopt the draft resolution.

Dr RATIH (Indonesia), recalling resolution WHA63.18 on viral hepatitis, expressed gratitude to all Member States for their efforts since its adoption in 2010 to tackle that particular health burden, as well as to the Secretariat for defining the core components of prevention and control programmes. Nevertheless, hepatitis B was still endemic in Indonesia and hepatitis C presented a new challenge; the percentage of patients diagnosed with viral hepatitis had doubled since 2007. Despite working hard to improve health technology, the country still suffered as a result of the high costs of diagnosis and treatment and limited access to good-quality care.

She urged the international community to commit itself to prioritizing viral hepatitis alongside the other well recognized public health issues of HIV/AIDS, malaria and tuberculosis. The draft resolution provided a good foundation for collaborative global action on viral hepatitis and Indonesia wished to be added to the list of sponsors.

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

The meeting rose at 12:30.

FIFTH MEETING

Wednesday, 21 May 2014, at 14:40

Chairman: Dr P. RENDI-WAGNER (Austria)

1. NONCOMMUNICABLE DISEASES: Item 13 of the Agenda

Maternal, infant and young child nutrition: Item 13.2 of the Agenda (Documents A67/15, A67/15 Add.1 and EB134/2014/REC/1, decision EB134(2))

The DIRECTOR-GENERAL, noting that FAO and WHO were working in close cooperation on preparations for the Second International Conference on Nutrition, welcomed the presence of the Director-General of the Food and Agriculture Organization of the United Nations at the meeting.

Dr GRAZIANO DA SILVA (Director-General, Food and Agriculture Organization of the United Nations) said that FAO and WHO would have the honour of welcoming Pope Francis at the Second International Conference on Nutrition. The Pope's participation reflected his commitment to food security and nutrition, which were central to the work of both FAO and WHO as long-standing partners in the organization of the Conference. Preparations were well under way and a joint FAO/WHO working group of Member States was working on the draft outcome documents. Member States' assistance was needed to ensure that the draft political declaration would be ready by the end of June 2014 and the draft technical framework for action by the end of July.

The Conference was a Government-led effort; to ensure that a range of voices was heard, parliamentarians should be included in the national delegations and both WHO and FAO had underlined the importance of involving non-State actors before, during and after the Conference, as they could contribute to the debate, strengthen decisions and generate political consensus to push the nutrition agenda forward and ensure adoption of the framework for action during the Conference. They would not, however, have the same role as governments, since they had no voting rights, even in the Committee on World Food Security. The Conference represented a unique opportunity to turn the international spotlight on nutrition and maximize its prominence in government agendas.

Ms MARTÍNEZ (Co-Chair, joint working group of regional representatives of FAO and WHO) said that the joint working group had reviewed the draft political declaration on 12 May 2014 and would receive further contributions to the document through online consultations. Further meetings would be held to complete the document by the end of June. The draft political declaration aimed to take up the general principles on ways of restructuring the nutrition system to meet the needs of the global population, and the principles would also be incorporated in a framework for action which would be drafted in collaboration with relevant United Nations bodies, nongovernmental organizations and the private sector. Non-State actors had participated from the outset in the public consultations without direct involvement in the face-to-face meetings. She asked the Health Assembly to support the draft decision recommended by the Executive Board,¹ to the effect that the working group should complete the draft outcome document for the Second International Conference on Nutrition, including a draft political declaration and a framework for action, and provide guidelines on the involvement of non-State actors in the preparations for the Conference, to be held in Rome in November 2014.

¹ See decision EB134(2).

Dr ALHAMAD (Kuwait) proposed deleting the phrase “on the development of recommendations for Member States on how to ensure appropriate marketing of complementary foods” in subparagraph (2)(d) of decision EB134(2), as “appropriate marketing” was inconsistent with the reference, earlier in the same paragraph, to “inappropriate promotion of food”.

Ms HARB (Lebanon) said that, despite the recent introduction of a law in Lebanon regulating the marketing and labelling of formula milk and banning its promotion, as well as legal action taken against milk companies, the formula milk industry often tried to circumvent the law. Nutrition was a striking example of the multisectoral approach to health, as its indicators applied not only to health, but to education, economic growth and social progress. Although the five actions proposed under the global strategy for infant and young-child feeding and comprehensive implementation plan on maternal, infant and young child nutrition (document A67/15, paragraphs 9–33) were commendable, her country had endured a massive influx of refugees and could not undertake the actions single-handedly. She therefore called on WHO and other international organizations to support its efforts to implement Lebanon’s national nutrition plan. She endorsed the seven indicators for monitoring progress towards the achievement of global targets, and the establishment of a working group to complete the global monitoring framework on maternal, infant and young child nutrition, as proposed in Annex 1 to document A67/15.

Dr BRYANT (Australia) called for a well-defined and coordinated approach to the double burden of malnutrition, relying on WHO’s expertise in the application of nutrition standards and system-wide coordination based on each United Nations body’s comparative advantage. Responding to the Secretariat’s request for guidance, she said that, in cases of conflict of interest, risk assessment and management tools should acknowledge the role that the private sector could play in promoting good nutrition and should take into account the framework for WHO’s future engagement with non-State actors. The global monitoring framework should capture the multisectoral nature of nutrition and be readily adaptable to a diverse range of country contexts. Taking into account the valuable input of the Scientific and Technical Advisory Group on the inappropriate promotion of foods for infants and young children, strategies should be considered that incentivized private sector actors to promote appropriate infant and young child feeding practices. The outcome document for the Second International Conference on Nutrition should be concise, strategic and multisectoral.

Dr LATIF (Afghanistan) noted that the call “to end inappropriate promotion of foods for infants and young children” contained in subparagraph 1(4) of resolution WHA63.23 had not been accurately reflected in subparagraph (2)(d) of decision EB134(2). He therefore suggested replacing the words “how to ensure appropriate marketing of complementary foods” in the latter paragraph with “how to eliminate all inappropriate promotion of foods for infants and young children”.

Dr NICOLETTI (Italy) welcomed the proposal in Annex 1 of document A67/15 to establish a working group to complete the global monitoring framework on maternal, infant and young child nutrition. Italy had made voluntary contributions to FAO and WHO for their work on the Second International Conference on Nutrition, which was to be held in Rome, and encouraged other Member States to do the same.

Mr BARBOSA (Brazil) said that his country represented the Region of the Americas, together with Mexico, on the joint working group discussing the preparations for the Second International Conference on Nutrition. Balancing the perspectives of FAO and WHO was positive and feasible, and he expected that working dialogue to be strengthened in the future.

Ms KOIVISTO (Finland) said that the objectives of health promotion, including the improvement of nutrition and the production of healthy food, overlapped with those of sustainable development. Indeed, the consumption and production of food represented one third of all factors

contributing to climate change. That was one of the topics informing the preparations for the Second International Conference on Nutrition, which could therefore be a crucial event in improving public health and reducing nutrition-related problems. Finland supported the preparations for the Conference and the mandate of the joint working group.

Dr GONZÁLEZ FERNÁNDEZ (Cuba) said that adequate lifelong nutrition for mothers would contribute to reducing the prevalence of low birth weight and stunting, and interventions should focus on nutrition for mothers throughout their reproductive life, followed by adequate nutrition for the infant, young child and adolescent. In Cuba, a national programme to protect, promote and support breastfeeding mothers and nutritional guidelines for children under two years of age encouraged better use of food and food habits. Nevertheless, the country was starting to experience problems of overweight in children under five years of age. Cuba attached great importance to the Second International Conference on Nutrition and was actively contributing to its preparation.

Ms CADGE (United Kingdom of Great Britain and Northern Ireland) thanked Member States for the commitments made at the Nutrition for Growth High Level Meeting (London, 8 June 2013), which supported progress towards achievement of the six global nutrition targets outlined in document A67/15 (paragraphs 3–8). The first global nutrition report, which was due to be launched at the Second International Conference on Nutrition in November 2014, would bring together global data, provide a comprehensive overview of the status of nutrition worldwide and help to track progress towards the global nutrition targets.

Ms MŪRMANE-UMBRAŠKO (Latvia) emphasized the importance of intersectoral and intergovernmental cooperation and of a “health in all policies” approach in national food and nutrition policies. The Health Assembly should provide guidance on risk assessment and management tools, the global monitoring framework, and how to address inappropriate marketing of complementary foods. She supported the Member State-driven process to develop a draft outcome document for the Second International Conference on Nutrition.

Dr USHIO (Japan) commended the emphasis placed in the report on initiatives outside the health sector, but pointed out that coordination with other programmes in the health sector, particularly maternal and child health programmes with the same target, was essential to the implementation of nutrition programmes. Coordination with noncommunicable disease programmes was also likely to become necessary in the future. For activities to be effective, programme managers at every level must coordinate with one another as well as with non-State actors. He supported the adoption of a global monitoring framework on maternal, infant and young child nutrition, and appreciated the proposal to tailor the extended set of indicators to specific situations, rather than report on a uniform set of indicators. Indicators should be clearly defined, based on thorough examination of scientific evidence, and neither too many nor too few for their intended purpose.

Ms YU Cheong-hee (Republic of Korea) said that, under a comprehensive national plan, her country was focusing its efforts on assessing and resolving the nutritional imbalance of vulnerable groups such as low-income and multicultural families. Separate nutrition guidelines would be required for expectant mothers, infants and young children. She recommended that all governments compile nutrition-related statistics, monitor nutrition closely, provide education and counselling on the topic, and promote balanced nutrition, with technical support from the Secretariat.

Dr ASUNCION (Philippines) said that the five actions described in document A67/15 provided helpful guidance to Member States on how to achieve the global targets. However, the implementation of action 4, on the provision of human and financial resources, posed a challenge for her country. The rightful prominence given to the International Code of Marketing of Breast-milk Substitutes in the report should serve as a constant reminder of the need to achieve health and nutrition outcomes for

infants and young children. She called on all Member States to adopt and uphold the Code and to ensure that violations were punishable by law. The Health Assembly should set a realistic deadline for the unanimous adoption of the Code in order to achieve the 2025 global targets.

Mr PABLOS-MENDEZ (United States of America), expressing appreciation for the Organization's involvement in the Scaling Up Nutrition movement, encouraged WHO to continue coordinating with other organizations of the United Nations system at the country and global level in order to harmonize their nutrition efforts. The food industry had a role to play in promoting good nutrition habits, and the rapid finalization of the risk assessment and management tools for conflicts of interest in nutrition should facilitate the transparent and productive engagement of the food industry in that area. The United States was a grateful user of several of WHO's nutrition programmes, such as the e-Library of Evidence for Nutrition Actions, the Global Database on the Implementation of Nutrition Action and the Nutrition Landscape Information System, which should be kept up to date by WHO.

Dr SANON (Burkina Faso), commending the five actions listed under the comprehensive implementation plan, highlighted the importance of action 2 on the introduction of effective health interventions with an impact on nutrition in national nutrition plans. In some countries, including hers, nutrition interventions were performed mainly in emergency situations, with few resources left for routine activities. Health system strengthening to remedy that deficiency would be highly desirable. The draft global monitoring framework referred to in Annex 1 to document A67/15 would be a valuable instrument for countries like her own, which had few nutrition indicators on the basis of which to target its nutrition interventions.

Dr KESKİNKILIÇ (Turkey) said that his country had successfully introduced a programme to promote breast milk and baby-friendly health institutions. Hospitals that had improved their practices through training programmes received the title of baby-friendly hospitals. Baby-friendly accreditation had subsequently been extended to the provinces and to family health units and newborn intensive care units. Every province in Turkey had at least one baby-friendly hospital, and 92% of newborns were delivered in baby-friendly hospitals.

Dr SAIPIN CHOTIVICHEN (Thailand) said that all seven global targets of the comprehensive implementation plan had been adopted as national targets in Thailand and legal tools were being developed to regulate the marketing of breast-milk substitutes. Progress in nutrition required multisectoral engagement, but in that context public health interests must be protected against conflicts of interest. That did not, however, preclude private operators who benefited from selling breast-milk substitutes, complementary food, and foods and beverages that promoted noncommunicable diseases from contributing to the solution. Their roles were limited to the manufacture, distribution, marketing and retail sale of food, excluding policy formulation and scientific processes. Regarding malnutrition, children were not malnourished because their mothers lacked knowledge, but because society failed to make nutritious food attractive and the market was flooded with cheap, high-energy and aggressively marketed foods and beverages. Thailand commended the Director-General for establishing the Commission on Ending Childhood Obesity to counter rising obesity trends.

Dr FERGUSON (Jamaica) expressed concern about the relationship between the health system and distributors and marketers of breast-milk substitutes, which had diversified their product lines and were marketing products aimed at managing noncommunicable diseases. The resulting conflict of interest was real, especially in view of the current financial environment. In addition, in the light of the increasing incidence of noncommunicable diseases, he recommended expanding the criteria for inappropriate marketing contained in Annex 2 to document A67/15 to include the promotion of foods and non-alcoholic beverages to adolescents and adults.

Dr KAMALIAH MOHAMAD NOH (Malaysia) noted with satisfaction that the proposed framework of engagement with non-State actors covered conflicts of interest in the area of nutrition. The framework, however, should also extend to noncommunicable disease prevention and control, where the private sector was an important stakeholder. She recommended that the core indicators under the draft global monitoring framework on maternal, infant and young child nutrition in document A67/15, Annex 1 be expanded to include body mass index for age in children under five years of age. Regarding the inappropriate promotion of foods for infants and young children in document A67/15, Annex 2, she supported the five criteria proposed by the Scientific and Technical Advisory Group for evaluating the appropriateness of promotion.

She commended WHO and FAO for organizing a Member State-driven process to develop a draft outcome document for the Second International Conference on Nutrition.

Dr CHAND (Nepal), referring to Nepal's involvement with three other countries in an assessment and research on child feeding project to guide policies on infant and young child nutrition, suggested that the Scientific and Technical Advisory Group be apprised of the project's results and that WHO should develop specific guidelines on each of the five criteria proposed by the Group in respect of inappropriate promotion of foods for infants and young children, in order to help countries to establish clear policies and regulations. Detailed advice would also be appreciated on cross-promotion of breast-milk substitutes and complementary foods; types of images and invitations to interact that were appropriate for consumers; appropriate nutrition claims for public health messages; and suggested wording for statements supporting breastfeeding and local foods. He urged Member States to implement and strengthen monitoring of the International Code of Marketing of Breast-milk Substitutes.

Mr DODDY IZWADI (Indonesia) said that his country was strongly committed to achieving the global targets under the comprehensive implementation plan on maternal, infant and young child nutrition, as was demonstrated by actions undertaken in the context of the Scaling Up Nutrition movement. To create a supportive environment for implementing comprehensive food and nutrition policies, Indonesia had developed food and nutrition action plans at the national and regional levels, each based on the pillars of community nutrition improvement; increasing food accessibility; increasing quality control and food safety; improving hygiene behaviour and healthy lifestyles; and strengthening food and nutrition institutions. The continuing technical support of WHO and other organizations of the United Nations system would help Indonesia to achieve its ambitious targets.

Ms THATANNE (Namibia) expressed concern about the minimal progress made towards achievement of the global nutrition targets set out in document A67/15, particularly for countries in the African Region. Regarding action 1 on the creation of a supportive environment for the implementation of comprehensive food and nutrition policies, Member States were often not able to recognize and anticipate potential conflicts of interest entailed by engagement with non-State actors, owing to the varying forms and interests of those actors. The Secretariat should strengthen the capacity of countries to engage with them effectively and compile a directory of the known actors and guidelines on potential conflicts of interest. Regarding action 2, on the inclusion of all required effective health interventions with an impact on nutrition in national nutrition plans, she requested the Secretariat to work on mainstreaming ready-to-use therapeutic foods for health care delivery, so that they reached those who most needed them. She expressed concern at the wording of the last sentence of the third paragraph of Annex 2; the statement "Where these products are on sale to the public, the potential for their inappropriate promotion needs to be considered" could create a false sense of security about the products concerned. A stronger recommendation was needed in order to protect countries from undue pressure to sell the products to the public, considering their potential effect of undermining the use of suitable home-prepared and local foods.

Dr ROY (Bangladesh) outlined his country's recent progress towards Millennium Development Goals 4 (Reduce child mortality) and 5 (Improve maternal health): child stunting and maternal undernutrition had been reduced significantly, the International Code of Marketing of Breast-milk Substitutes had been adopted by law (although conflicts of interest remained to be addressed) and the exclusive breastfeeding rate had increased to 64%, and most hospitals had been made baby-friendly. Vitamin A distribution was almost universal; more than 70% of consumers used iodized salt and supplementation with iron and folic acid reached up to 60% of eligible women. Maternal nutrition throughout the life course was being incorporated into national nutrition services. Outstanding challenges included micronutrient deficiencies, which were widespread. Bangladesh was reformulating its national nutrition policy in order to prevent child obesity and an increase in noncommunicable diseases, including the promotion of home-based complementary food. Adequate support from the United Nations and donor agencies was requested to ensure the sustainable success of Bangladesh's health care system.

Dr TAKIAN (Islamic Republic of Iran) welcomed WHO's collaboration with FAO in preparing the Second International Conference on Nutrition. The draft documents for the Conference should reflect the threat posed by noncommunicable diseases, especially during the first two years of a child's life, and stress healthy nutrition habits. Similarly, given the world's increasing susceptibility to global warming, the Conference would provide a good opportunity to discuss food security. His Government had established a high council for food security and health, led by the President, to consider food security on a multisectoral basis, and was willing to share its experience. It had also recently increased the length of maternity leave to two years, with job security, in order to encourage breastfeeding.

Dr KALANTARI (Islamic Republic of Iran), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that the Second International Conference on Nutrition would provide a good opportunity to reach a global agreement on action priorities to reshape the food system and make it more responsive to health needs. The draft political outcome document should include provisions on: enforcing national nutrition policies and strategies that tackled the double burden of malnutrition and contributed to global nutrition targets and to the WHO global action plan for the prevention and control of noncommunicable diseases 2013–2020; soliciting support from policy-makers for strategic interventions, including integrating nutrition counselling in primary health care, supplementation, food fortification, promoting a healthy diet, growth monitoring and surveillance, and implementing the International Code of Marketing of Breast-milk Substitutes; concluding partnerships with other organizations of the United Nations system, nongovernmental organizations and local communities; and discussing the role of industry and non-State actors in the nutrition implementation plan, taking into account the prevention of conflicts of interest. The framework for action should provide operational details of how different sectors could contribute to the goal of improving diet and nutrition, and should include WHO's nutrition and noncommunicable disease targets.

Dr PRASAD (India) said that his Government had implemented various measures in line with the provisions of several Health Assembly resolutions, including resolution WHA65.6 on the comprehensive implementation plan on maternal, infant and young child nutrition and resolution WHA34.22 on the International Code of Marketing of Breast-milk Substitutes. Those measures included adapting WHO's guidelines on both facility-based and community-based management of severe acute malnutrition, adopting the WHO Child Growth Standards, establishing nutrition rehabilitation centres in every district and providing iron and folic acid supplements to pregnant women and adolescents. Health officials had been trained in the implementation of those strategies at community level.

He read out the national 15-point leadership agenda for action established with support from partners and civil society. The agenda included a wide range of multisectoral actions to deal with issues related to maternal, infant and young child nutrition.

Ms IBRAHIM (Maldives) said that her country depended almost entirely on imports of food, even staples. Despite the challenges faced, the indicators for underweight children, stunting and wasting had declined substantially between 1996 and 2009. The delivery of health care services, including the distribution of essential health supplies to health service providers, was a logistical challenge, and difficulties in retaining health care personnel on remote islands for long periods of time affected the continuity of programmes. It was important to raise awareness not only among health care professionals, but also vulnerable groups, on the availability, accessibility and methods for handling the commodities referred to in the newborn health draft action plan (document A67/21). Maldives would welcome support from health partners to help it to develop its regulatory capacity in food usage and handling, draft relevant guidelines and discourage the marketing of unhealthy food and beverages.

Ms WANG Qiaomei (China) supported in principle the draft decision recommended in decision EB134(2) and approved the proposal to draw up recommendations before the end of 2015 to counter the inappropriate promotion of foods, taking into account the importance of nutritional supplements. China promoted breastfeeding in various ways, including by focusing efforts on pregnant women to ensure that they were in good health before giving birth; taking into account differences between urban and rural areas and the specific needs of underdeveloped regions; and providing weekly nutritional supplements to children aged between 6 and 24 months.

Mrs BAYBARINA (Russian Federation) said that serious efforts had been made in her country to promote and popularize breastfeeding and optimize nutrition for children. The report should have included a section on therapeutic nutrition for premature and sick newborns to prevent such children from having excessive or insufficient body mass, which in turn would link the document with the newborn health draft action plan and the integrated programme for noncommunicable diseases prevention and control.

Dr AL ABRIYA (Oman) welcomed the establishment of a joint working group to develop the draft outcome document for the Second International Conference on Nutrition. Strategies for improving maternal, infant and young child nutrition in line with the global strategy for infant and young-child feeding had been adopted as part of the Sultanate's five-year health plan, which guaranteed the financial and human resources required for implementation. The Sultanate was also striving to create a support structure for the implementation of comprehensive feeding and nutrition policies, including micronutrient feeding, through a multisectoral partnership. In 2013, it had updated its code of conduct for the use and promotion of breast-milk substitutes in line with Health Assembly resolutions in order to meet the challenges of inappropriate marketing of infant and young child foods, and it had recently reviewed its breastfeeding policy, in cooperation with WHO. Maternal, infant and young child nutrition targets were included in the health system, as were indicators for monitoring progress towards achievement of the global targets.

Dr NDOUNDO (Chad), expressing appreciation for the report, said that his country had developed a multisectoral plan on maternal, infant and young child nutrition, with a focus on the link between health and nutrition. While endorsing the draft agenda of the Second International Conference on Nutrition, he stressed the need to tailor solutions to the local level, taking account of good cultural practices and locally available ingredients for use in therapeutic foods.

Dr AL-TAAE (Iraq) said that efforts to promote maternal, infant and young child nutrition must be aligned with strategic nutrition and food safety plans, which in turn should be integrated into reproductive health actions and efforts to tackle risk factors for noncommunicable diseases. Noting that breastfeeding constituted an important initial source of immunization for infants, he highlighted the need to promote the development of more baby-friendly hospitals and primary health care centres. Breastfeeding should be encouraged as the recommended approach and legislation on the International Code of Marketing of Breast-milk Substitutes should be enacted. Advocacy, awareness-raising and

civil society engagement were necessary to change behaviour. With multisectoral involvement, his country had focused efforts on combating micronutrient deficiency by fortifying flour with iron and folic acid and salt with iodine, and providing vitamin A supplements through the vaccination programme and to schoolchildren.

Dr RASHID (United Republic of Tanzania), speaking on behalf of the Member States of the African Region, acknowledged the substantial progress achieved under the comprehensive implementation plan on maternal, infant and young child nutrition and its six global targets. Stunting remained a major problem in the Region, affecting 40% of children under five years of age in sub-Saharan Africa. Efforts to scale up proven nutrition and nutrition-sensitive interventions must therefore be intensified. To combat anaemia, which affected more than half of all pregnant women and children under five years of age in the Region, a multifaceted approach was required, including improved access to iron, folic acid and affordable foods fortified with micronutrients. Low birth weight remained a challenge in many African countries, highlighting the need for interventions during preconception and optimal nutrition for adolescent girls. The prevalence of childhood obesity, which currently stood at 8.5% in the Region, continued to rise, resulting in a double burden of obesity and undernutrition. Both facets of the problem must therefore be targeted. In that regard, he welcomed the establishment of the Commission on Ending Childhood Obesity and emphasized the importance of tracking the trend in childhood obesity in African countries. Efforts to promote breastfeeding should be further strengthened; in some parts of Africa less than 50% of children under six months of age were exclusively breastfed. Wasting affected between 7% and 12% of children under five years of age in the Region, indicating the need for enhanced action at the community level to ensure improved access to food and child care.

Change needed a multisectoral approach, with the pivotal role for the health sector. The sustainability and long-term success of the global response to maternal, infant and young child nutrition would depend to a large extent on health system capabilities, and increased support must therefore be provided to Member States to strengthen health systems. The initiatives carried out in collaboration with the Scaling Up Nutrition movement were an important part of the process. Expressing concern that only 22% of countries had enacted legislation on the International Code of Marketing of Breast-milk Substitutes, he urged all stakeholders to accord the Code high priority and support countries in its enforcement. He welcomed the five criteria in Annex 2 to document A67/15 to determine whether promotion of foods was inappropriate, but noted the need for more detailed and specific guidance to deal with the full spectrum of marketing and promotion practices.

He commended the establishment of the FAO/WHO joint working group of Member States and requested the directors-general of both organizations to facilitate the finalization of the draft outcome document before the Second International Conference on Nutrition.

Dr KHAWAJA (Bahrain) welcomed the preparations for the Second International Conference on Nutrition and outlined the Bahraini vision for improving nutrition, which entailed: integration of the maternal and child health programme with nutrition programmes; promotion of foods supplemented with micronutrients such as vitamin A, iron and iodine, and measures to reduce salt content; establishment of age-appropriate nutrition programmes, with a view to changing dietary habits through education and community-based programmes; development of feeding and nutrition policies for pregnant women and infants; coordination of a database and advice on health and nutrition interventions for women and infants; and provision of the human and financial resources needed to implement programmes for pregnant women and infants. The private sector and food industries were important partners in implementing the national plans in those spheres. Further indicators were needed in order to monitor progress towards achieving the global targets.

Mr LUTZOW STEINER (Mexico) said that, in the context of an intersectoral programme to combat hunger and extreme poverty, his Government had introduced a strategy to strengthen services for mothers, newborns and children under five years of age, which included promoting exclusive

breastfeeding up to the age of six months and creating breastfeeding-friendly environments and facilities, including human milk banks. Those actions were complemented by a range of national health policies, including provision of vaccines, monitoring of maternal and infant nutrition and participatory education and training. He underlined the need to strengthen services for infants in order to reduce morbidity and mortality in accordance with the principles of gender equality and health equity. Universal screening for hearing impairments, retinopathy and other disabilities in newborn infants should also be envisaged. Supporting the proposals contained in document A67/15, he emphasized the need to strengthen information systems at the local level, enhance health personnel training and increase community participation, with a focus on preventing teenage pregnancy and harnessing multisectoral efforts.

Dr ZAKARIA (Ghana), recognizing the importance of intersectoral action to improve infant and young child nutrition, said that her Government had set up an interministerial committee to develop a national nutrition policy, with the participation of all stakeholders.

Dr VALVERDE (Panama) noted with satisfaction the progress made towards achieving the targets defined in the global strategy and comprehensive implementation plan. Access to nutritionally adequate food was a basic human right, for the realization of which a multisectoral, multidisciplinary approach was required, together with coordination of policies and legislation. In that connection, her country had introduced and was successfully implementing a national food security and nutrition plan. The Second International Conference on Nutrition would form a vital component of efforts to define future policies. Emphasizing the importance of breastfeeding as a public health priority, she said that her Government had introduced a law and regulations on the subject.

Ms BRUNET (Canada) acknowledged the critical importance of the health sector in making further progress towards nutrition targets through effective interventions and strengthened surveillance systems. She endorsed the set of seven indicators to monitor progress on maternal, infant and young child nutrition, as set out in Annex 1 to document A67/15, and welcomed the proposal to establish a working group to develop further indicators. She called for alignment with the work of the global health agency leaders group convened by WHO and the World Bank with the aim of reducing the number of health indicators. She strongly encouraged WHO to establish a framework of engagement with non-State actors and draw on the extensive work undertaken by the Scaling Up Nutrition movement to develop conflict-of-interest guidance and tools. She requested further clarification of WHO's guidelines on conflicts of interest in nutrition. Welcoming the update on the Second International Conference on Nutrition, she said that WHO's full engagement would ensure that the Conference served as a positive demonstration of the collaborative efforts by the health and agriculture sectors to improve nutrition.

Ms CHOZOM (Bhutan) said that her country attached high priority to improving maternal, infant and young child nutrition. Efforts in Bhutan were under way within the framework of a national five-year plan to achieve the six global targets, including work to reduce the prevalence of stunting to less than 30%, and to decrease the prevalence of wasting in children under five years of age to less than 3% by 2018. Her country was on track to achieve the global target of reducing low birth weight. She underscored the need for a "health in all policies" approach to nutrition.

Dr SUNDARANEEDI (Trinidad and Tobago) said that the global targets in the comprehensive implementation plan on maternal, infant and young child nutrition highlighted priority areas for further work and provided a benchmark against which to measure national achievements, identify gaps and take corrective action. Various initiatives were being undertaken in Trinidad and Tobago to tackle the multiple burden of a rise in chronic diseases, childhood and adult obesity, low birth weight, anaemia, low breastfeeding rates and inadequate complementary feeding. Relevant policies included a national

nutrition education programme, a childhood obesity prevention policy and a national nutrition workforce strategy and implementation plan to strengthen human resources capacity for nutrition.

Mr EMANUELE (Ecuador) said that nutrition was a priority under his country's national development plan. Engagement with the private sector (document A67/15, paragraph 14) could pose challenges, in particular with regard to defining policies to regulate marketing, as evidenced by Ecuador's current difficulties in implementing the national code of conduct for producers and marketers of formula milk and breast-milk substitutes. For that reason, it was essential to establish mechanisms to monitor and prevent conflicts of interest. In line with the recommendation contained in Annex 2 to document A67/15, he called for the establishment of an indicator on continued breastfeeding of infants until two years of age.

Dr BROU (Côte d'Ivoire) welcomed the progress made in achieving the global targets set out in the comprehensive implementation plan. Côte d'Ivoire had made advances in reducing levels of stunting and low weight and improving the rate of exclusive breastfeeding, but further efforts were needed to reduce wasting, anaemia and obesity. A multisectoral, multi-stakeholder platform had been established to revise and develop national food and nutrition policies and legislation had been enacted to enforce the International Code of Marketing of Breast-milk Substitutes. In order to significantly reduce malnutrition, action should be taken to strengthen nutritional surveillance systems, introduce nutrition-related interventions at all levels, mobilize financial and human resources, and enhance strategies to tackle iron deficiency.

Dr WAPADA (Nigeria) said that scaling up nutrition interventions to ensure optimal maternal, infant and young child nutrition was a Nigerian priority for reducing hunger and undernutrition. Nigeria's nutrition interventions focused on infant and young child feeding, treatment of acute malnutrition via community management, micronutrient deficiency control and nutrition information surveillance systems. Expressing support for the global monitoring framework, he said that his Government had developed a range of policies into which the elements of the framework had been incorporated.

Dr Shu-Ti CHIOU (Chinese Taipei) welcomed the draft decision recommended in decision EB134(2). Promotion of breastfeeding was an integral part of Chinese Taipei's life course approach to the prevention and control of noncommunicable diseases. As a result of various initiatives at the national level, the number of baby-friendly hospitals had increased, the rate of exclusive breastfeeding for infants aged six months or less had reached 48.7%, the availability of breastfeeding facilities and environments had increased and measures had been taken to enable mothers to breastfeed at their places of employment. Chinese Taipei had endorsed the International Code of Marketing of Breast-milk Substitutes and had enacted legislation to restrict the sales, promotion or advertising of unhealthy foods for children. She welcomed the draft global monitoring framework and the development of risk assessment and management tools for conflicts of interest in nutrition.

Ms SMITH (International Lactation Consultant Association), speaking at the invitation of the CHAIRMAN, said that an increase in exclusive breastfeeding rates would have a follow-on effect on reduction targets for wasting, stunting and obesity among children and anaemia among mothers. The International Code of Marketing of Breast-milk Substitutes was a crucial instrument that must be incorporated into national legislation if it was to be effectively implemented. She urged WHO to continue promoting breastfeeding in order to achieve the related Millennium Development Goals of reducing child mortality and improving maternal health.

Ms BRINDEN (The International Association for the Study of Obesity), speaking at the invitation of the CHAIRMAN and on behalf of Consumers International and other nongovernmental organizations, endorsed the targets adopted under the global strategy and the actions being taken by

WHO on the marketing of complementary foods in order to bridge the gap between the early infancy protection afforded by the International Code of Marketing of Breast-milk Substitutes and the protection of older children making their own food choices under the WHO set of recommendations on the marketing of foods and non-alcoholic beverages to children. The Second International Conference on Nutrition should reassert human health priorities in relation to the glaring need to reshape the entire food supply chain to meet the nutritional needs of populations. WHO must seek support from nongovernmental organizations in the development of risk assessment and management tools for conflicts of interest in nutrition, which were necessary in order to protect the integrity and reputation of organizations engaging with commercial actors.

Mr DAWSON (World Vision International), speaking at the invitation of the CHAIRMAN, welcomed the progress made in achieving the six global targets set out in the comprehensive implementation plan but said that current efforts should be accelerated. The nutrition targets must remain high on the global agenda, particularly in the context of the post-2015 development agenda and the sustainable development goals. He strongly encouraged the timely, comprehensive development and implementation of the global monitoring framework, which should include sets of core and extended indicators and measure the scaling-up of cost-effective interventions, including a target for the reduction of child anaemia. He called on all stakeholders to ensure a participatory and inclusive process at the Second International Conference on Nutrition and to produce a strong outcome document.

Mrs BAUMGARTEN (The Save the Children Fund), speaking at the invitation of the CHAIRMAN, said that nutrition-related targets must continue to be accorded high priority on the global agenda, including the post-2015 development agenda. She underlined the importance of continued close consultation with civil society in the work of completing the global monitoring framework. The linkages between the global monitoring framework and other accountability frameworks currently being developed under commitments arising from the Nutrition for Growth high-level meeting and the framework for action being discussed for the Second International Conference on Nutrition should be clearly defined. The indicators contained in the global monitoring framework should be further disaggregated by income quintile, location, gender, ethnicity and disability, and the age group indicators should be disaggregated to include 10–14 and 15–19 year-olds, in addition to infants and young children. Noting that the Second International Conference on Nutrition provided an opportunity to harness multisectoral initiatives on nutrition, she emphasized the need to create a clear framework for action that would deliver tangible outcomes.

Dr HAWKES (Union for International Cancer Control), speaking at the invitation of the CHAIRMAN, welcomed the opportunities offered by the Second International Conference on Nutrition to examine all forms of malnutrition and the impact of food systems on nutrition. A list of clear, actionable commitments that tackled the relationship between malnutrition and food systems should be created. Civil society organizations like her own would be engaged in the conference process and welcomed collaboration with Member States in order to strengthen the focus on food systems both in the political outcome document and in the framework for action. The Conference's agenda should be carried forward to the post-2015 discussions.

Dr QUINN (Helen Keller International), speaking at the invitation of the CHAIRMAN, stressed development of more detailed guidance to help countries to formulate clear policies and regulations for the appropriate marketing of complementary foods, including specific guidelines on the five criteria set out in Annex 2 to document A67/15 to evaluate whether promotion of foods for infants and young children was inappropriate. Detailed advice was also required on issues such as the cross-promotion of breast-milk substitutes and complementary foods, the appropriateness of images and invitations to interact with consumers, the appropriateness of nutrition claims to communicate public health messages, and the suggested wording for a statement supporting breastfeeding and the role of

local foods. She also stressed implementation and enhanced monitoring of the International Code of Marketing of Breast-milk Substitutes and called for the inclusion of follow-up milk formulas in the Code. Nutrition must be given priority in the post-2015 dialogue on sustainable development goals.

Ms ALLAIN (International Baby Food Action Network), speaking at the invitation of the CHAIRMAN, emphasized the need for effective guidelines to tackle conflicts of interest, but expressed concern that the Scaling Up Nutrition movement was involved in WHO's nutrition policy development and programming despite the potential for conflicts of interest in its internal operating procedures. The draft decision recommended in decision EB134(2), which was not consistent with resolution WHA63.23 given that it referred to "appropriate marketing" rather than "inappropriate promotion", should include the five criteria contained in Annex 2 to document A67/15 to evaluate whether promotion of foods for infants and young children was inappropriate. She regretted that many Member States had not yet implemented the International Code of Marketing of Breast-milk Substitutes and stressed the need to increase implementation of the global strategy for infant and young-child feeding. For that purpose, realistic investment would be essential and her organization's World Breastfeeding Costing Initiative, a budgeting tool supported by the World Bank, could support Member States in planning and budgeting for infant and young child feeding interventions.

Dr SOW (Global Health Council, Inc.), speaking at the invitation of the CHAIRMAN, expressed concern at the slow progress made in achieving the targets set out in the comprehensive implementation plan and noted the importance of scaling up nutrition interventions through effective and sustainable health system delivery and integration within primary health care systems. Greater alignment was required between the six global targets and other elements of the Health Assembly's agenda, as well as the ongoing discussions on the post-2015 development agenda. She called on WHO and its international partners to increase support for accurate diagnosis of health systems; enhance coordination between frameworks, diagnostic tools, technical expertise and funding for health system strengthening; include a "tracer indicator" and reporting within the future global framework; and ensure consistency between the global nutrition targets, ongoing health system reforms and the post-2015 development agenda. She further called for the adoption, at the Sixty-eighth World Health Assembly, of a resolution highlighting the need for appropriate and systematic integration of nutrition interventions into health systems.

Dr VAN LIERE (Global Alliance for Improved Nutrition), speaking at the invitation of the CHAIRMAN, said that to achieve the six global targets it would be essential to implement comprehensive, multisectoral national programmes to tackle malnutrition; adopt the recommendations contained in WHO's publication *Landscape analysis on countries' readiness to accelerate action in nutrition: country assessment tools* (2012); and support further elaboration of the five criteria for evaluation of the inappropriate promotion of industrially processed complementary foods. Nutrition should be the core focus of the sustainable development goals.

Dr CHESTNOV (Assistant Director-General) thanked delegates for their constructive comments. It was clear that countries accorded importance to making further progress on the six global targets by amending policies, ensuring funding and engaging in global advocacy. The new, more effective reporting tools would allow Member States to set their own targets and track progress. In cooperation with partner agencies and organizations, WHO was preparing a detailed draft outcome document for the Second International Conference on Nutrition. The guidance on effective nutrition actions had been updated and policy briefs for the implementation of action required to achieve the targets had been developed. He noted the need to ensure better integration of programmes for effective nutrition into health systems in order to reinforce universal health coverage for the sake of direct nutrition interventions. He expressed appreciation for Member States' engagement in and commitment to the Second International Conference on Nutrition, which would provide an opportunity to reach a

global agreement on action priorities to reshape the food system in order to better meet populations' health care needs.

Dr GRAZIANO DA SILVA (Director-General, Food and Agriculture Organization of the United Nations) said that his organization would work with WHO to put delegates' helpful comments, suggestions and guidance into effect in a timely manner. He welcomed the request made by the delegate of Italy for countries to provide additional funding for the Second International Conference on Nutrition.

The DIRECTOR-GENERAL thanked Member States and the Director-General of FAO for their comments. The current discussion provided an important opportunity for countries to understand the collaborative efforts undertaken by WHO and FAO to serve both organizations. Although Member State-driven action was an essential part of the process, the coordination of such action across two organizations could prove challenging. She expressed appreciation for the interministerial work carried out and for the funding provided for the Second International Conference on Nutrition. Further guidance and advice would be sought from Member States to determine how best to coordinate efforts between the two organizations.

The CHAIRMAN invited the Secretary of the Committee to read out the proposed amendments to the draft decision recommended in decision EB134(2).

Mr ROBERTS (Assistant Secretary) said that subparagraph (2)(d), with the amendment proposed by the delegates of Afghanistan and Kuwait, would read: "noting the work carried out by the WHO Secretariat in response to resolution WHA65.6, in which the Director-General was requested to provide clarification and guidance on the 'inappropriate promotion of foods for infants and young children' cited in resolution WHA63.23, taking into consideration the ongoing work of the Codex Alimentarius Commission; recalling resolution WHA63.23, in which Member States were urged to end inappropriate promotion of food for infants and young children; and requesting the Director-General to complete the work, before the end of 2015, for consideration by Member States at the Sixty-ninth World Health Assembly".

The CHAIRMAN took it that, in the absence of any objections, the Committee wished to approve the draft decision, as amended.

The draft decision, as amended, was approved.¹

2. COMMUNICABLE DISEASES: Item 12 of the Agenda (continued)

Hepatitis: Item 12.3 of the Agenda (Documents A67/13, A67/13 Add.1 and EB134/2014/REC/1, resolution EB134.R18) (continued from the fourth meeting, section 2)

Mrs ESCOREL DE MORAES (Brazil), speaking in her capacity as facilitator of the informal consultations on the draft resolution recommended for adoption in resolution EB134.R18, said that as a result of broad participation in those consultations, agreement had been reached on those parts of the text that had not been finalized at the 134th session of the Executive Board, namely the fifteenth preambular paragraph and operative subparagraph 1(14). The fifteenth preambular paragraph would now read: "Recalling United Nations General Assembly resolution 65/277, paragraph 59(h), which

¹ Transmitted to the Health Assembly in the Committee's third report and adopted as decision WHA67(9).

recommends ‘giving consideration, as appropriate, to implementing and expanding risk- and harm-reduction programmes, taking into account the *WHO, UNODC, UNAIDS Technical Guide for Countries to Set Targets for Universal Access to HIV Prevention, Treatment and Care for Injecting Drug Users*, in accordance with national legislation’, as important components of both HBV and HCV prevention, diagnosis and treatment programmes and that access to these remain limited or absent in many countries of high HBV and HCV burden”. A footnote referencing the Technical Guide had been included in the text.

Operative subparagraph 1(14) would read: “to implement comprehensive hepatitis prevention, diagnosis and treatment programmes for people who inject drugs, including the nine core interventions, as appropriate, in line with the *WHO, UNODC, UNAIDS Technical Guide for Countries to Set Targets for Universal Access to HIV Prevention, Treatment and Care for Injecting Drug Users*, and in line with the global health sector strategy on HIV/AIDS, 2011–2015, and the United Nations General Assembly resolution 65/277, taking into account the domestic context, legislation and jurisdictional responsibilities;”. A footnote detailing the nine core inventions had been inserted into the text.

(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 17:25.

SIXTH MEETING

Thursday, 22 May 2014, at 09:25

Chairman: Dr P. RENDI-WAGNER (Austria)

1. THIRD REPORT OF COMMITTEE A (Document A67/65)

Dr MBUGUA (Kenya), Rapporteur, read out the draft third report of Committee A.

The report was adopted.¹

2. COMMUNICABLE DISEASES: Item 12 of the Agenda (continued)

Hepatitis: Item 12.3 of the Agenda (Documents A67/13, A67/13 Add.1 and EB134/2014/REC/1, resolution EB134.R18) (continued from the fifth meeting, section 2)

Mrs ESCOREL DE MORAES (Brazil) said that the various meetings and consultations held with representatives of all regional groups since the 134th session of the Executive Board had resulted in proposed amendments to preambular paragraph 15 and operative subparagraph 1(14) of the draft resolution recommended in resolution EB134.R18. The amended texts would read, respectively:

“Recalling United Nations General Assembly resolution 65/277 paragraph 59(h) which recommends ‘giving consideration, as appropriate, to implementing and expanding risk- and harm-reduction programmes, taking into account the WHO, UNODC, UNAIDS Technical Guide for Countries to Set Targets for Universal Access to HIV Prevention, Treatment and Care for Injecting Drug Users² in accordance with national legislation’,³ as important components of both HBV and HCV prevention, diagnosis and treatment programmes and that access to these remain limited or absent in many countries of high HBV and HCV burden;” and

“to implement comprehensive hepatitis prevention, diagnosis and treatment programmes for people who inject drugs including the nine core interventions,⁴ as appropriate, in line with the WHO/UNODC/UNAIDS Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users, and in line with the Global Health

¹ See page 347.

² Available from www.who.int/hiv/pub/idu/targetsetting/en/index.html.

³ WHO/UNODC/UNAIDS Technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users. Geneva: World Health Organization; 2009.

⁴ Needle and syringe programmes; opioid substitution therapy and other drug dependence treatment; HIV testing and counselling; antiretroviral therapy; prevention and treatment of sexually transmitted infections; condom programmes for people who inject drugs and their sexual partners; targeted information, education and communication for people who inject drugs and their sexual partner; vaccination, diagnosis and treatment of viral hepatitis; prevention, diagnosis and treatment of tuberculosis.

Sector Strategy on HIV/AIDS, 2011–2015, and the UNGA Resolution 65/277, taking into account the domestic context, legislation and jurisdictional responsibilities;”.

Dr ALLAH-KOUADIO (Côte d’Ivoire) said that her country had a very high prevalence of hepatitis B compared with other African countries. The many steps it had taken included creation of a national control programme, free treatment with pegylated interferon and guidance on treatment of coinfections with HIV. The main challenges remaining were to introduce hepatitis B vaccination at birth (implying an additional dose of monovalent vaccine); to validate rapid tests for hepatitis B and C; to create a register of viral hepatitis cases; and to provide free antiviral treatment for carriers of hepatitis B virus. She fully supported the framework for global action to prevent and control viral hepatitis infection and requested the support of partners to improve access to medicines.

Dr SANON (Burkina Faso) quoted two figures to illustrate the extent of the problem in her country: 10% of blood donors were positive for markers of hepatitis B infection and 75% of patients with viral hepatitis had hepatocellular carcinoma. Prevention and control efforts focused mainly on vaccination of children and health care workers. Shortcomings included poor knowledge of the extent of the problem, poor organization of care services, the absence of diagnostic equipment, and above all insufficient vaccination. She called for the Secretariat to advocate technical and financial support. She supported the draft resolution.

Dr HARVEY (United Kingdom of Great Britain and Northern Ireland) congratulated the delegation of Brazil, other Member States and the Secretariat for the exemplary fashion in which they had engaged with non-State actors to produce a draft resolution that all could accept. The draft resolution and the resulting increased focus on viral hepatitis, a significant health burden in many countries, provided a real opportunity to make progress globally.

Ms SOVD TUGSDELGER (Mongolia) said that, although Mongolia had a high prevalence of viral hepatitis and one of the highest rates of liver cirrhosis and cancer in the world for want of early detection and treatment of hepatitis B and C, the prohibitively high costs of medicines limited treatment options almost exclusively to symptomatic management. She supported the draft resolution, in particular the call for all relevant United Nations entities and other stakeholders to include prevention, diagnosis and treatment of viral hepatitis in their work programmes and to provide sustainable funding for that purpose. She emphasized integrated programmes for HIV infection, sexually transmitted infections and hepatitis in order to capitalize on the significant effort and funds invested by the Global Fund to Fight AIDS, Tuberculosis and Malaria. WHO should focus on facilitating equitable access to effective and safe hepatitis treatments and diagnostics, especially in high-burden countries.

Dr DORO (Mauritania) observed that his country had a very high prevalence of both hepatitis B and D. The Government had recently decided to establish a national hepatitis virology institute which would also serve as a national and subregional focal point for diagnostics and treatment. He supported the draft resolution.

Dr MAINA (Kenya) encouraged countries to adopt the proposed comprehensive approach to prevention and control. Universal infant immunization was the ideal strategy for the early long-term control of chronic hepatitis B virus infection and its sequelae, but the proposal in the draft resolution for a birth dose of the vaccine needed review. As the route of transmission of hepatitis B viruses was mainly horizontal rather than perinatal, vaccination at birth might not have a significant advantage over vaccination at six weeks of age. He supported the draft resolution, but recommended that subparagraph 1(7) be reviewed to take account of the fact that countries were already administering hepatitis vaccinations at six weeks under their routine immunization programmes and that their efforts should be strengthened by measures other than the introduction of the birth dose.

Dr HANSA RUKSAKOM (Thailand) tempered her support for the draft resolution with two main concerns. First, although the number of new technologies and interventions for prevention, control and treatment was growing, health resources were finite and hepatitis had to compete with other health priorities. Countries needed ways to ensure evidence-based decision-making that took account of, for example, disease burden, programmatic issues, budget impact, and programmatic and financial sustainability. WHO should support and strengthen institutional policy-making capacity and strike a balance among prevention, control and treatment strategies. Secondly, the uneven progress of prevention programmes indicated an urgent need for greater political and financial commitment, competent staff in sufficient numbers, and effective hepatitis programme management at national and subnational levels. WHO should scrutinize hepatitis programmes more closely. Furthermore, in order to promote synergies and conserve resources, hepatitis programmes should be integrated with related programmes, such as those on HIV/AIDS, blood safety, immunization, harm reduction and safe injection in health care settings.

Dr NARGIS (Bangladesh) recalled resolution WHA63.18, which had urged an integrated approach to the prevention, control and management of viral hepatitis. As most Member States did not have a surveillance system for viral hepatitis that enabled them to take evidence-based policy decisions, multisectoral national strategies for preventing, diagnosing and treating viral hepatitis should be developed and implemented in the light of the local epidemiological context. In Bangladesh, the priority needs were a national evidence-based policy and communication tools for preventing hepatitis B infection. The high prevalence of hepatitis B virus markers in pregnant women demanded compulsory screening of all pregnant women for hepatitis B and treated, as necessary, with hepatitis B immunoglobulin and newborns given a birth dose of vaccine. Domestic vaccine production was also needed, so as to provide vaccine at an affordable price and to boost the national mass vaccination programme.

Dr KHAWAJA (Bahrain) noted the report on hepatitis and the numerous challenges for public health services. She also noted and supported the draft resolution, which covered all important directions for global, regional and national action against viral hepatitis.

Ms DANIAULT (France) thanked Egypt and Brazil for having spearheaded the work on the draft resolution; France wished to join the sponsors. Insufficient screening programmes meant that the burden of disease due to viral hepatitis could only be estimated. To rectify that situation needed systematic early diagnosis, better surveillance and improved data collection worldwide as well as research and development of new diagnostic tests, treatments and vaccines; the French national research agency was spending 20% of its €10 million budget on viral hepatitis. Optimism generated by new treatments was tempered by their high costs. The International Drug Purchase Facility (UNITAID) had a couple of weeks previously offered grants to lower the market barriers to new treatments for viral hepatitis, including coinfections with HIV. However, with three new infections for every case cured, a further challenge was prevention, in particular universal vaccination of children against hepatitis B. Other essential preventive measures included safe blood transfusion and harm reduction in vulnerable groups, especially injecting drug users.

Dr DANG QUANG TAN (Viet Nam) fully supported the adoption of the draft resolution. Consistent with its proposed actions, Viet Nam had already implemented prevention and control activities, including establishing guidelines on hepatitis C diagnosis and treatment and including hepatitis B vaccination in the national Expanded Programme on Immunization. He requested the Secretariat to provide technical support for the development of a national plan for viral hepatitis prevention and control covering surveillance, laboratories, treatment, immunization, blood safety and health promotion. He also requested continued support from WHO and other international organizations to ensure continued access to hepatitis vaccines while immunization coverage increased.

Ms ST LAWRENCE (Canada) said that people who inject drugs were the major risk group in Canada for HIV and hepatitis C virus coinfection. Its approach to the problem included preventing infection and transmission, promoting abstinence from illicit drug use and facilitating access to medication for addicts, with guaranteed equal access to treatment, medication and essential services, in order to create the supportive environments necessary for effective prevention, care and support. She thanked Brazil for its constructive leadership of the drafting group on the draft resolution and expressed support for its adoption, as amended.

Dr RIVERA (Bolivarian Republic of Venezuela) said that his country prioritized viral hepatitis as a public health problem and was making strenuous efforts to improve environmental health conditions in major towns, for the benefit of lower-income sectors of the population. He noted with concern the alarming costs of treatments and the issues of market dynamics; high prices precluded access to treatment for lower-income groups – an example of economic interests trumping health needs. Universal health systems were needed in order to guarantee free access to treatment. He urged the Secretariat to increase its support to Member States in establishing and applying multisectoral coordinated strategies based on local epidemiological contexts for preventing, diagnosing and treating chronic viral hepatitis and strengthening the capacity of associated primary health care professionals.

Ms YU Cheong-hee (Republic of Korea) asked for her country to be listed as a sponsor of the draft resolution. Successful hepatitis management required support at national level in the form of surveillance, budget allocations, awareness-raising, and appropriate interventions in the vaccine and pharmaceutical markets. Her country had maintained high rates of hepatitis B vaccination among infants and young children and covered the cost of serological testing. It had been the first country in the Western Pacific Region to obtain certification for achievement of the hepatitis B control goal, in 2007. WHO should create opportunities other than the Health Assembly to discuss response measures and enhance awareness of chronic infections.

Ms RIOS (Argentina) commended the Secretariat's responses to viral hepatitis. In 2012, her Government had established a national programme to control viral hepatitis (mainly A, B and C), which focused on access to diagnosis and treatment. Immunization against hepatitis A and B was part of the national immunization schedule and was therefore obligatory, universal and free of charge. In 2005, single-dose immunization with hepatitis A vaccine had been introduced (the first country in the world to do so), and subsequent findings had substantiated the cost-effectiveness of the approach. Before 2004, hepatitis A was the leading cause of acute liver failure and transplantation in children, but after 2007 no transplant for that reason was done. Analysis of the economic impact showed that between 2000 and 2004 treatment of such patients cost US\$ 50 million, whereas between 2006 and 2010 the vaccination programme had cost US\$ 25 million. The Strategic Advisory Group of Experts on immunization had endorsed the strategy, and Colombia and Paraguay had incorporated single-dose hepatitis A vaccination in their immunization schedules.

Increased surveillance and detection of cases of viral hepatitis were needed, and promotion, prevention and treatment activities needed to be strengthened. Accordingly, she endorsed the draft resolution, but strongly recommended that it place greater emphasis on promotion and prevention.

Dr DEELCHAND (Mauritius) expressed support for the draft resolution. The country's prevention strategy relied mainly on hepatitis B vaccination, which was included in the national Expanded Programme on Immunization for adults at risk as well as children. Providing treatment for people with hepatitis B and C was currently beyond the reach of many countries; Mauritius would have to allocate a huge part of its national health budget to do so. The pharmaceutical industry should make treatments for hepatitis B and C available at an affordable price; patients should not suffer the resulting discrimination.

Ms IBRAHIM (Maldives) acknowledged WHO's establishment of the Global Hepatitis Programme and the elaboration of the framework for global action to prevent and control viral hepatitis infection, especially as viral hepatitis and its complications were estimated to cause more deaths in the South-East Asia Region than malaria, dengue and HIV/AIDS combined. Maldives included a birth dose of hepatitis B vaccine in its immunization schedule and had achieved more than 95% coverage. Procurement and maintenance of an adequate supply of vaccines presented difficulties. The high cost of treatment and care was a major concern. She asked the Secretariat to provide information on its work to update the WHO list of prequalified serological tests for hepatitis B and C.

Countries need to build their capacities to plan and implement viral hepatitis prevention and control programmes. Those in the South-East Asia Region had worked to mobilize resources for the implementation of the regional strategy for the control and prevention of viral hepatitis issued in 2013. She supported the draft resolution.

Ms EASTER (United States of America), noting that the enormous global disease burden of viral hepatitis had been significantly underappreciated to date, was pleased at the consensus that had emerged for a strong resolution. Global viral hepatitis prevention and control efforts, hampered by a fragmented and uneven approach, had been only partially successful. Greater attention should be paid to implementation of the global strategy, prevention through universal early immunization against hepatitis B, and, in particular, improvement in infection control practices to prevent hepatitis C virus infection. Member States should, in addition to following the recommendations set out in the draft resolution, include the birth dose of hepatitis B vaccine, as appropriate in the national context, in their immunization strategies, and include chronic hepatitis B and hepatitis C surveillance in their viral hepatitis surveillance systems. The Secretariat should, as needed, provide Member States with the technical support required to develop robust surveillance strategies. Routine surveillance was particularly important for enhanced understanding of the epidemiology of hepatitis outbreaks. The Secretariat should provide proactive guidance for Member States to establish and maintain effective national viral hepatitis prevention and control programmes, including appropriate treatment.

Professor BAGGOLEY (Australia) thanked Brazil and the other sponsors of the draft resolution for their work during the recent informal discussions that resulted in agreement on a final text. He welcomed the work of the Secretariat on drafting technical guidance to help Member States to strengthen their hepatitis surveillance programmes and to update the WHO list of prequalified hepatitis B and C serological tests for issue in 2014. Member States should improve surveillance in order to generate accurate data on disease burden for policy-makers, and include at-risk population groups in prevention programmes. Vaccination was the basis for preventing hepatitis B, and his country therefore provided funding to national health programmes in the Indo-Pacific region to ensure access to good-quality prevention and treatment services, including in the form of support for routine immunization to WHO, UNICEF and the GAVI Alliance.

Mrs MELNIKOVA (Russian Federation) recognized the need for action to strengthen epidemiological surveillance of viral hepatitis, new tools for screening and testing, new treatments and access thereto, and implementation of prevention programmes. Her country had one of the highest rates of screening for viral hepatitis in the world and included hepatitis B vaccine in its mass immunization campaign. It paid particular attention to protecting medical staff against occupational infection. The State was providing diagnosis and treatment of viral hepatitis in people coinfecting with HIV. She welcomed the development of new medicines against hepatitis C, but shared the concerns about their high costs and the consequent inadmissible restrictions on access. International mechanisms should be used to procure medicines, so as to reduce cost while maintaining high quality. Efforts should be made to introduce innovative technologies to contain epidemics and to support the development of new prevention strategies.

She supported the draft resolution as amended by Brazil, and welcomed the reference in operative subparagraph 1(14) to legislation.

Mr SEY (Gambia) said that the Gambia Hepatitis Intervention Study Programme had observed a drop in the number of liver cancer cases among persons aged 18 to 24 years since the introduction of the hepatitis B vaccine in 1990. The Study Programme had not established a direct link, however, and it would take about 30 years, i.e. until 2017 in the case of Gambia, to determine the exact impact of vaccination. It had also found that the childhood prevalence rate had fallen to very low levels since the introduction of the vaccine. His Government was also participating, in partnership with institutions in France, Italy, Nigeria, Senegal, and the United Kingdom of Great Britain and Northern Ireland in a study called PROLIFICA (Prevention of Liver Fibrosis and Cancer in Africa), funded by the European Commission, to identify the causes of liver cancer in West African populations and show whether effective treatment of hepatitis B virus infection could prevent the disease. Its results could make a significant contribution to improving the health status of Gambians, other West Africans and the world at large. He noted the report and considered the draft resolution.

Dr JAFARIAN (Islamic Republic of Iran) agreed that, although new diagnostics and medicines were causes for optimism, their price was a major barrier, especially in respect of hepatitis C and hepatocellular carcinoma in hepatitis B patients. In some countries, many hepatitis C patients were injecting drug users and prisoners who could not afford care. National strategies should work to reduce the cost of care; but WHO, also, had a crucial role to play in advocating lower costs.

Dr BEN SALAH (Tunisia) said that viral hepatitis was also a health and safety issue in the workplace. Health care workers and others who were at risk of exposure through work should be protected by vaccination against hepatitis B, and policies should stress safe injections and the necessity of not reusing syringes.

Professor GASSAYE (Congo) endorsed the draft resolution. She underlined the need for a birth dose of hepatitis B vaccine. For hepatitis C, whose treatment was very costly, WHO should engage in advocacy with manufacturers for reductions in price. As HIV coinfection aggravated the course of viral hepatitis, health professionals should mobilize in support of better information, education and communication.

Ms FERNÁNDEZ DE LA HOZ ZEITLER (Spain) welcomed the draft resolution, which took a holistic approach, and expressed support for its adoption as amended. Hepatitis surveillance systems were crucial for establishing the burden of disease and providing reliable information for policy-makers. The Secretariat played a valuable role in guiding countries and supporting the development of viral hepatitis prevention and control strategies. It should seek synergies with strategies to prevent other infectious diseases and control noncommunicable diseases, as well as continue working with Member States and other partners to advance the cause of preventing and treating viral hepatitis.

Dr SHAHANIZAN MOHD ZIN (Malaysia) expressed support for the draft resolution. With the advent of new and more effective treatments for hepatitis B and C, WHO should facilitate negotiations to make them more affordable. She welcomed the Secretariat's efforts to draft technical guidance to help Member States to strengthen their hepatitis surveillance programmes and treatment guidelines for hepatitis B and C. The importance of hepatitis B vaccination in preventing cirrhosis of the liver and liver cancer was gaining recognition, prompting the Western Pacific Region to adopt the following slogan for its Regional Immunization Week 2014: "Stop hepatitis B and liver cancer. Vaccinate at birth."

Dr PRASAD (India) said that India had prioritized hepatitis as a priority public health issue, acting as a pioneer in the South-East Asia Region. The national immunization policy recommended three doses of hepatitis B vaccine and a birth dose for newborns born in health care facilities. He endorsed the draft resolution with the proposed amendments. India favoured giving Member States the flexibility to establish national harm-reduction policies in the light of national legislation, policies and

procedures. With regard to the recent licensing of new medicines for the treatment of hepatitis C and WHO's issuing of new treatment guidelines, the larger issue for India and low- and middle-income countries was equitable access to affordable high-quality diagnostics and medicines. That issue should receive the necessary resources and attention to ensure the necessary impact on hepatitis control.

Ms BRATSYUN (Ukraine) expressed support for the draft resolution. Against the background of a national programme for providing adequate treatment for patients with hepatitis C, she expressed concern at the high price of medicines, which made it difficult for all patients to obtain treatment. She drew particular attention to procedures for screening donated blood.

Ms MATSOSO (South Africa) thanked Brazil and Egypt for spearheading the deliberations on the draft resolution and asked for South Africa to be added as a sponsor. The report made clear the enormous benefits that would follow if access to treatment for hepatitis C were improved. The projected achievement was surely one that the Health Assembly should support. Consistent with that effort, other barriers had to be tackled in a comprehensive approach. When it came to financial access, for example, the HIV/AIDS experience had demonstrated that coverage could be improved when treatment was affordable. Physical access to treatment should also be improved, by ensuring access to primary care facilities that were equipped with ultrasound machines and staffed by well-trained personnel. Hepatologists were a rare commodity, and consideration should be given to the report's proposals for the training of other categories of health workers. She commended the Secretariat's inclusion of pegylated interferon in the 18th WHO Model List of Essential Medicines and its work on treatment. Without prevention measures and control programmes, the fight against hepatitis would be lost.

Ms DUSSEY-CAVASSINI (Switzerland) thanked Brazil for its efforts to produce a draft resolution that all delegations could support. One of WHO's goals was universal health coverage, which by definition meant that every single person had to be taken into account as a matter of individual health and public health concern. Efforts in that direction were needed for vulnerable groups, including injecting drug users. It was from that perspective that she supported the draft resolution as amended.

Dr SUNDARANEEDI (Trinidad and Tobago) expressed support for the draft resolution. His Government was committed to improving the health status of the population through a well-coordinated Expanded Programme on Immunization. It had aligned its immunization policies and practices with those recommended in the draft resolution, introducing compulsory vaccination for all health personnel and standardized infection control practices, including bodily fluid precautions across its network of health institutions. In order to improve on current practices, the Government hoped to receive continued technical support for maximizing synergies between viral hepatitis prevention, diagnosis and treatment programmes and the work on implementing the WHO global action plan for the prevention and control of noncommunicable diseases 2013–2020.

Dr MALEFHO (Botswana) said that Botswana remained committed to making vaccines available to all children under the age of five years. Coverage with hepatitis B vaccine had been raised to between 80% and 100% in the years 2011–2013 through various strategies to increase access to routine immunization services: Reaching Every District, Child Health Days, observance of African Vaccination Week and hepatitis B vaccination of health care workers. An effort remained to be made in the African Region to raise awareness about viral hepatitis among the general public and to expand its prevention and control. Aspects that required strengthening included the integration of viral hepatitis services into health services and the reinforcement of surveillance systems so as to allow better determination of the burden of disease. He supported the draft resolution and urged the Secretariat to provide Member States with technical support to enable them to intensify measures to prevent, diagnose and treat hepatitis.

Dr IBRAHIM (Somalia) said that estimates of hepatitis B and C virus prevalence among healthy blood donors in his country indicated that it was among those countries with high hepatitis B endemicity. The strategies used to prevent transmission included screening blood for hepatitis B and C virus before transfusion, injection safety and awareness-raising. However, screening services were limited to urban areas and quality assurance standards among private health care providers were low. No prevention programmes targeted high-risk groups, including injecting drug users. Sustainability and infrastructure were major challenges, and new methods were required in order to minimize the rate of transmission. In low- and middle-income countries, medical care was complicated, costly and in short supply, and needed to be expanded to primary health care facilities. The international community, civil society organizations and governments must engage in stronger advocacy for lower prices for hepatitis treatment.

Mr CALDAS DE MESQUITA (Brazil) said that tackling chronic viral hepatitis was a global challenge, but with few international resources and actors. Among several important initiatives in recent years were the inclusion of hepatitis in the UNAIDS Strategy 2013–2016, the greater involvement by civil society organizations, especially in relation to access to medicines, and the side event on viral hepatitis held during the Sixty-sixth World Health Assembly. That event had paved the way for the collective work that had resulted in the draft resolution before the Committee, and he thanked all the Member States that had collaborated in the drafting process. The high-quality debate in the current Health Assembly and the number of Member States that had announced their wish to sponsor the draft resolution were gratifying. The draft resolution provided for an intersectoral approach to prevention, diagnostics, treatment and immunization.

Control of viral hepatitis still faced numerous challenges and would require steps such as: campaigns for increased vaccination against hepatitis A and B, harm-reduction measures, rapid diagnosis, trained medical teams, updated guidelines and accessible treatment. The involvement and leadership of WHO and its regional offices were essential to guide Member States. He acknowledged the guidelines on hepatitis C treatment,¹ launched in April 2014, and the incorporation of the Global Hepatitis Programme into the HIV/AIDS department, and urged the Secretariat to continue the recruitment of hepatitis experts to the staff of regional offices – Brazil had just seconded one to PAHO.

Brazil welcomed recent technological advances, such as point-of-care diagnostics and oral medicines with shorter treatment courses. It was unacceptable that such advances should be beyond the reach of governments and people because of their high prices, and the issues of access to medicines, increased competition, more accessible generic therapeutic alternatives that were safe, efficacious and of good quality, and the use of flexibilities for public health under the World Trade Organization Agreement on Trade-Related Aspects of Intellectual Property Rights as appropriate must be considered.

The CHAIRMAN thanked the delegation of Brazil for the work it had done to produce the draft resolution.

Dr VALVERDE (Panama), recalling that, without diagnosis or referral for care and treatment, one third of patients with chronic viral hepatitis would die of liver cancer or cirrhosis, said that Panama had incorporated hepatitis A and B vaccination into its national immunization schedule. The national coverage rate was 95%. Hepatitis B vaccine was administered at birth and at two, four and six months, to adolescents aged 13 to 15 years, and to groups at risk. She supported the draft resolution.

¹ Guidelines for the screening, care and treatment of persons with hepatitis C infection. Geneva: World Health Organization; 2014.

Ms SHERRY-AYITTEY (Ghana) acknowledged the burden of disease due to viral hepatitis, especially hepatitis B, in her country. The Government had introduced vaccination for children. Treatment was very expensive and most people in rural and hard-to-reach communities had no access to diagnosis or treatment. Other challenges included assuring the supply of vaccines, building laboratory capacity for diagnosis, improving public awareness, and strengthening prevention and surveillance. She supported the draft resolution, but expressed regret that it did not sufficiently promote research into early diagnosis and the need for sound data.

Dr ACENG (Uganda) said that Uganda faced a heavy burden of hepatitis B and C and experienced frequent outbreaks of hepatitis A. The prevalence of hepatitis B ranged up to 30%; hepatitis B virus and HIV coinfections worsened patients' prognosis, and complications such as cirrhosis and hepatocellular carcinoma added to the burden. The country had introduced routine infant immunization in 2002 and was vaccinating all high-risk groups, starting with health care workers. It had elaborated a comprehensive plan for prevention, control and care. She appealed for improved affordability of and access to medicines and diagnostic tools for hepatitis B management and control.

Dr NDOUNDO (Chad) said that, although no accurate figures were available, viral hepatitis and chronic hepatitis B and C in particular were serious health problems in his country. Chad faced exorbitant prices of vaccines for groups not targeted by the Expanded Programme on Immunization and of medicines for treatment. Awareness must be raised, with a particular emphasis on screening, even though laboratory costs were also unaffordable to a large swathe of the population, and on healthy lifestyles and diet. The Secretariat should take account of those points in developing clear and specific guidance for Member States.

Mr CHANG-HSUN Chen (Chinese Taipei) appreciated the report and the draft resolution. The first programme of free mass vaccination of children against hepatitis B was introduced in 1984 in Chinese Taipei and the vaccination coverage had remained high, at more than 97%. Vaccination against hepatitis A had dramatically reduced the incidence rate between 1995 and 2013. Since 2003, Chinese Taipei's health insurance covered treatment of chronic hepatitis B and C, but the high cost of new hepatitis C medicines was hindering their introduction. He appealed to WHO to work with stakeholders to provide affordable access to hepatitis C medicines.

Ms CONN (MSF International), speaking at the invitation of the CHAIRMAN, expressed great concern that the cost, complexity, low success rates and side effects of the treatment against hepatitis C barred its implementation in low- and middle-income countries. Screening and treatment of hepatitis B were not supported in many low- and middle income countries. Recent developments, including more effective direct-acting antivirals and new WHO guidelines, offered opportunities for progress in the treatment of hepatitis C and B in such countries. The draft resolution could be strengthened by urging Member States to implement hepatitis B birth-dose vaccination; by emphasizing price-reducing generic competition for the newest hepatitis C treatments and protecting the use of flexibilities in the Agreement on Trade-Related Aspects of Intellectual Property Rights for that purpose; by urging WHO to include hepatitis C medicines in its prequalification programme; and by persuading donors to prioritize hepatitis B and C treatment in their funding.

Mr ELYAMANI (Medicus Mundi International – International Organisation for Cooperation in Health Care), speaking at the invitation of the CHAIRMAN, welcomed the draft resolution. Noting the intellectual property and cost barriers to new hepatitis C treatments, he called for national legislation that ensured the use of the flexibilities in the Agreement on Trade-Related Aspects of Intellectual Property Rights in order to guarantee access. The reference in the draft resolution to coordinated multisectoral responses should include measures to reduce transmission through medical or dental procedures. The Secretariat should provide technical support to certain Member States to enhance surveillance, prevention and treatment measures, and amend intellectual property legislation to secure

access to new hepatitis C medicines. Detailed references on harm-reduction policies in the resolution should not be included if they would impede its adoption.

Mr GORE (World Hepatitis Alliance), speaking at the invitation of the CHAIRMAN, thanked the Member States, especially Brazil, for their work on the draft resolution. He welcomed the robust national plans, whose development illustrated Member States' commitment to prevention, diagnosis and treatment of viral hepatitis. In many States, however, attaining those objectives was hindered by the absence of global funding mechanisms. Such a mechanism would only be created if the post-2015 development agenda included indicators for hepatitis, for which he urged Member States to advocate. The elimination of hepatitis B had long been envisaged and the possibility of eliminating hepatitis C had become foreseeable, provided that treatment was affordable. Setting goals was essential to progress, as illustrated by the targets in the Western Pacific Region for reducing the prevalence of hepatitis B in children and the achievements of the States of that Region. He urged Member States to use the regional committees to set objectives for the diagnosis and treatment of viral hepatitis.

Ms GOPFERT (International Federation of Medical Students' Associations), speaking at the invitation of the CHAIRMAN, expressed concern that monopolies driven by intellectual property would price new treatments for hepatitis C beyond the reach of most patients. The voluntary licensing concessions made by private sector producers were not sufficient to allow for sustainable treatment. Her organization was disappointed that, instead of new medicines, WHO had included older, less effective hepatitis C treatments in the 18th WHO Model List of Essential Medicines. She urged Member States to evaluate new hepatitis treatments for inclusion in the List; to use the flexibilities in the Agreement on Trade-Related Aspects of Intellectual Property Rights to improve access to hepatitis C medicines; to recognize that patent-driven research and development threatened access to treatment in many countries; and, in view of the rising prices of patent-protected medicines, to pursue models driven by medical need, not intellectual property.

Dr NAKATANI (Assistant Director-General) thanked the Member States for their interventions, particularly appreciating the work done by Brazil and Egypt. The questions and comments from Member States had fallen into four broad areas. First, in the area of access to medicines and diagnostics, it was true to some extent that lessons learnt in the field of HIV would be valuable, but it had to be borne in mind that the situation for hepatitis was somewhat different. With regard to the prequalification programme, 15 diagnostic tests each for hepatitis B and C were being evaluated. Additional tests would be considered for prequalification as they became available.

Secondly, he agreed that prevention was crucial, including blood safety, food and water safety, and infection control. Specifically, as 80% of hepatitis B infections occurred within the first year of life, and vaccination needed to be given as early as possible, preferably within the first 24 hours of life, followed by two or three more doses in the first year of life as a primary series.

Thirdly, given the scale of viral hepatitis as a public health problem, treatment should be expanded and integrated into general health systems and evidence-based policies needed to be implemented. Fourthly, it was undoubtedly true that hepatitis surveillance programmes needed to be improved.

Achievement of those objectives would be facilitated by both the Health Assembly's consideration of the draft resolution and financial contributions from Member States. Once the resolution was adopted, the Secretariat would act, it was to be hoped, with a fully-funded budget.

The CHAIRMAN took it that, in the absence of any comments, the Committee wished to approve the draft resolution, as amended by Brazil, contained in resolution EB134.R18.

The draft resolution, as amended, was approved.¹

3. NONCOMMUNICABLE DISEASES: Item 13 of the Agenda

Prevention and control of noncommunicable diseases: Item 13.1 of the Agenda (Documents A67/14, A67/14 Add. 1, A67/14 Add.2 and A67/14 Add.3)

Professor HALTON (Australia, representative of the Executive Board) recalled that the Executive Board at its 134th session, in January 2014, had considered a report covering various consultations among Member States on the topic and containing the terms of reference for the United Nations Inter-Agency Task Force on the Prevention and Control of Non-communicable Diseases, the limited set of action plan indicators for the WHO global action plan for the prevention and control of noncommunicable diseases 2013–2020 and a progress report on implementation of the action plan for the global strategy for the prevention and control of noncommunicable diseases 2008–2013. Many Member States had taken the floor to comment on and express appreciation for the work by the Secretariat in collaboration with other organizations of the United Nations system, and to note that consensus had been reached during the first meeting of the Inter-Agency Task Force in October 2013 on its draft terms of reference.² The updated reports were contained in document A67/14.

The Board had requested the Director-General to prepare a short report on WHO's role in the preparation and implementation of and follow-up to the United Nations General Assembly's comprehensive review and assessment in 2014 of the progress achieved in the prevention and control of noncommunicable diseases (document A67/14 Add.2).

A second formal meeting of the Task Force had been convened in April 2014 to conclude work on the terms of reference for the global coordination mechanism (see document A67/14 Add.1). At that meeting the Secretariat had been requested to prepare a work plan for the global coordination mechanism for the prevention and control of noncommunicable diseases for the period 2014–2015, which was submitted in document A67/14 Add.3.

Mr MESBAH (Algeria), speaking on behalf of the Member States of the African Region, said that action at global, regional and national levels was needed in order to lighten the burden of noncommunicable diseases in the African Region, where it fostered inequality. The Region had contributed to the development of policies based on the Brazzaville, Moscow and New York declarations on noncommunicable diseases. However, insufficient funding, inadequate information systems and the growing number of interventions needing technical and human resources prevented many countries from attaining those goals. He welcomed the joint African Union Commission-WHO meeting (Luanda, 14–17 April 2014), at which a declaration that included a commitment by African health ministers to work on policies and strategies to counter noncommunicable diseases was adopted.

He commended the terms of reference for the Inter-Agency Task Force and underscored its role in strengthening international cooperation. The global coordination mechanism should improve stakeholders' participation. Close cooperation with Member States was needed during the appointment of members of the working groups, based on equitable geographical representation. The problem of access to medicines for noncommunicable diseases must be clearly recognized and innovative mechanisms set up to ensure that access. Investment plans for resource mobilization must be drawn up, aimed particularly at building health system capacity. Support must be sought from North–South and triangular partnerships to deal with the shortcomings in research in the Region; and the

¹ Transmitted to the Health Assembly in the Committee's fourth report and adopted as resolution WHA67.6.

² See document EB134/2014/REC/2, summary record of the second meeting, section 2, and the third meeting, section 2.

international community should respond to developing countries' need for technology transfer and capacity-building.

Dr AMMAR (Lebanon) recalled that WHO would play an active role in the preparation of the comprehensive review and assessment regarding the Political Declaration of the High-level Meeting of the United Nations General Assembly. It was critical that the global coordination mechanism be led by Member States and protected from undue influence. The Political Declaration was not yet being effectively implemented by the Inter-Agency Task Force at country level. Giving effect to the global coordination mechanism and developing process indicators to monitor progress at national level were prime concerns. It was also important to consider countries' varying capacities to measure progress on objectives and indicators. Further support from the Secretariat was therefore required in the development of national targets and legislation to implement the Political Declaration.

Dr KESKİNKILIÇ (Turkey) welcomed the evident political will to tackle noncommunicable diseases and the progress made on the terms of reference for the global coordination mechanism, but noted that much work remained to be done. Prevention and control of noncommunicable diseases were challenges requiring cooperation among stakeholders and participation by all sectors of society. Although Member States might have system-based action plans for noncommunicable diseases, overarching action plans that incorporated life course approaches were needed. He encouraged WHO to develop tools to enable the exchange of best practices regarding noncommunicable diseases.

Dr PRASAD (India) said that his Government had set up departments responsible for noncommunicable diseases and tobacco control, with integrated operational guidelines in use, and had adopted the nine voluntary global targets for noncommunicable diseases by 2025, together with a regional target on indoor air pollution. A national cancer register existed. The WHO Framework Convention on Tobacco Control had also been successfully implemented. India had been the first country to develop its national monitoring framework in line with the global monitoring framework for noncommunicable diseases, and its national action plan for prevention and control of noncommunicable diseases was being drawn up to include the delivery of comprehensive services and continuity of care.

Dr ALWOTAYAN (Kuwait) expressed support for the proposals in the reports, endorsing the need to focus on the determinants of noncommunicable diseases, the elderly and primary health care, in particular through strengthening primary health care programmes in medical centres. Awareness-raising campaigns and service provision needed attention globally. Data should be reported regularly and databases on people with noncommunicable diseases could be usefully created in prevention and medical centres. She endorsed the draft global action plan.

Mr KRANIAS (Greece), speaking on behalf of the Member States of the European Union, said that Turkey, the former Yugoslav Republic of Macedonia, Montenegro, Iceland, Serbia, Albania, Bosnia and Herzegovina, Ukraine, Republic of Moldova, Armenia and Georgia aligned themselves with his statement. He welcomed the progress on the implementation of the action plan for 2008–2013. He noted with appreciation that the work plan for the global coordination mechanism 2014–2015 took into account the recommendations and suggestions of the Political Declaration. He accepted the text as it stood, although it was not elegantly formulated, but with the following proposed amendment in paragraph 13 of the terms of reference for the working groups (document A67/14 Add.3, Annex): the words "as observers" should be replaced by "for consultation". In addition, he suggested inserting the standard footnote on non-State actors as in the terms of reference for the global coordination mechanism (document A67/14 Add.1, Annex, Appendix 1, paragraph 5).

Progress on noncommunicable diseases would be made only with international and national multisectoral commitment, under the leadership of WHO and with an adequately financed and resourced secretariat for the global coordination mechanism. Although engagement with non-State

actors would contribute to reducing noncommunicable diseases, it should be in line with WHO's guidance to protect public health from undue influence. With the additional measures submitted for adoption by the current Health Assembly, a comprehensive presentation on noncommunicable diseases was ready for submission to the United Nations General Assembly comprehensive review and assessment high-level meeting which would guide the global response to noncommunicable diseases. He therefore proposed that the Committee should: adopt the action plan indicators for 2013–2020; recommend the submission of the terms of reference for the Inter-Agency Task Force to the United Nations Economic and Social Council; endorse the terms of reference for the global coordination mechanism; and note the amended work plan for the global coordination mechanism. He requested that the Director-General should report back to the Sixty-eighth World Health Assembly on the comprehensive review and assessment and WHO's subsequent action to be taken in that regard.

Dr MAAROUFI (Morocco) stated that his country was among the first Member States of the Eastern Mediterranean Region to develop a multisectoral action plan in line with the Political Declaration and the WHO action plan 2013–2020, which had involved 15 national partners from various sectors, including nongovernmental organizations, in order to tackle risk factors and to define the roles of different government departments. In preparation for the high-level meeting scheduled for July 2014, he supported the position of the Eastern Mediterranean Region regarding the creation of mechanisms to monitor and evaluate the implementation of the commitments made under the Political Declaration. He recommended inclusion of prevention and control of noncommunicable diseases in the post-2015 development agenda; provision by the Secretariat of technical support, where needed, in designing national targets for 2025; and definition of the roles of non-State actors in the implementation of the Political Declaration, including accountability.

Dr TARAWNEH (Jordan) noted the reports and approved the Secretariat's work in following up on the General Assembly's high-level meeting. Her Government had created a ministerial commission and a small interministerial working group that reported directly to the Prime Minister. It had also adopted a national action plan on noncommunicable diseases, which was aligned with WHO's draft action plan. Implementation of the plan had, however, been delayed because of the influx over the past two years of some 1.5 million refugees and the consequent strain on resources.

Dr AL HAJERI (Bahrain), speaking on behalf of the Member States of the Eastern Mediterranean Region, acknowledged the challenges faced in reaching consensus on the work plan for the global coordination mechanism. She generally supported its objectives, but a mechanism to monitor and evaluate implementation of the Political Declaration and the action plan for 2013–2020 with agreed process indicators needed to be set up. Members of the working groups should be appointed in full consultation with the regions and their governing body mechanisms. A mechanism should be established to monitor contributions from other stakeholders, particularly the private sector and civil society, to work on the commitments to the Political Declaration and the achievement by 2025 of the global targets adopted by the Health Assembly in resolution WHA66.10.

Dr NARGIS (Bangladesh) welcomed the reports and recalled that the burden of noncommunicable diseases disproportionately affected the poor and increased inequality. WHO's active leadership and the framework it had drawn up would serve to guide policy-makers and development partners in developing countries, where the issue of noncommunicable diseases, which had not received adequate attention, was a particular burden. Commending WHO's work so far on noncommunicable diseases, she nevertheless expressed concern that many developing countries might not be in a position to respond effectively to the WHO indicators and targets, and therefore urged the Secretariat to provide technical support to her country in order to achieve the nine voluntary global targets.

Dr TRIMBLE (United States of America) welcomed the reports. He noted the progress on the follow-up to the Political Declaration, the development of indicators to monitor implementation of the action plan, which he accepted, and the terms of reference for the global coordination mechanism, which should be adopted. He recommended forwarding the terms of reference for the Inter-Agency Task Force to the United Nations Economic and Social Council for its consideration and encouraged that Task Force to consider ways to increase the participation by other United Nations bodies. Monitoring tools should also be strengthened to allow all indicators to be captured and data to be improved, while minimizing the reporting burden on countries and WHO.

He recognized the importance of a nimble mechanism under WHO leadership to improve global collaboration. The global coordination mechanism, while encouraging the engagement of non-State actors in implementing evidence-based strategies and drawing on their expertise, should acknowledge the unique qualification of public health agencies to measure trends in noncommunicable diseases and evaluate population-based strategies. At the same time, WHO needed to be protected from undue influence. For example, the statement “non-State actors ... may be invited by the WHO Secretariat to Working Group meetings as observers” (document A67/14 Add.3, Annex, paragraph 13), did not create the impression of a forward-looking partnership capable of tackling the burden of disability, morbidity and premature mortality due to noncommunicable diseases.

Dr GRABAUSKAS (Lithuania), affirming the heavy burden of noncommunicable diseases on health and the economy of his country, strongly supported WHO’s initiatives, which had culminated in the Political Declaration and the action plan for 2013–2020. He commended the report in document A67/14 and underlined the importance of the voluntary global targets for noncommunicable diseases by 2025 and the indicators for the action plan for 2013–2020 for monitoring the latter’s implementation at WHO’s different levels. The success of the action plan would depend on strengthening national capacity to formulate relevant policies on the basis of health in all policies, broader public health action, universal health coverage, integrated health care and improved surveillance. He noted with satisfaction that the European Commission’s programme of action for health (2014–2020), which was under consideration by the European Parliament, placed considerable emphasis on noncommunicable diseases.

Dr NYARKO (Ghana) welcomed the reports. Noncommunicable diseases constituted a major burden for countries in sub-Saharan Africa, including Ghana. Progress had been made and it was to be hoped that the proposed framework would assist in further advancing work.

Ms ST LAWRENCE (Canada) welcomed the reports and highlighted WHO’s leadership in the global dialogue on noncommunicable diseases, which had resulted in significant progress. She appreciated the efforts of Member States to reach consensus on the terms of reference for the global coordination mechanism and the rapid elaboration of the corresponding work plan. The “community of practice” cited in action 4.1 of the work plan (document A67/14 Add.3) would be strengthened by a multisectoral approach, which would in turn support an inclusive and results-oriented global coordination mechanism.

Mr ŽEROVEC (Slovenia), noting that alcohol consumption remained one of the main risk factors for noncommunicable diseases, appreciated the Secretariat’s work on the Global status report on alcohol and health 2014 and the collection of case studies on alcohol policy development and implementation, in support of the WHO global strategy to reduce the harmful use of alcohol. WHO had a crucial role in providing more effective leadership and better use of evidence-based practices in order that the voluntary target of a 10% reduction in the harmful use of alcohol be reached by 2025.

Dr SIMA (Ethiopia), recognizing the risk factors for noncommunicable diseases, their health and economic burden, and the urgent problem caused by their interaction with infectious diseases, said that her country had initiated several national and regional prevention and control programmes. It had

developed a national strategic framework and action plan, and allocated a budget for noncommunicable diseases. It was also currently conducting a national survey to determine the burden of disease. Its undertakings were in line with WHO's recommended policies and strategies.

Mrs ESCOREL DE MORAES (Brazil) considered that implementation of the action plan for 2013–2020 was urgent and that dialogue should be established with various actors and stakeholders, modelled on the Pandemic Influenza Preparedness Framework. Reinforcing Member States' ownership and leadership would guarantee the integrity of WHO in relation to its engagement with non-State actors. In Brazil, the Government maintained a fruitful partnership with civil society and industry; the same could be achieved at global level.

She proposed the following amendments to the terms of reference for the time-bound Working Groups (document A67/14 Add.3, Annex): in paragraph 3, the phrase "from a roster of experts prepared by Member States" should be inserted at the end of the first sentence after the word "experience"; in paragraph 4, the words ", including the Chair," should be deleted and the sentence "In addition, each Working Group shall be co-chaired by representatives of two Member States, one from a developed and another from a developing country, to be appointed in consultation with Member States." should be added at the end of the paragraph; in paragraph 11, the sentence "A briefing to Member States will be held after each meeting of the Working Groups." should be added at the end of the paragraph; and in paragraph 13, the words "as observers" should be deleted and the words "for consultation" should be inserted either between the words "may be invited" and "by the WHO Secretariat" or at the end of the paragraph in place of the deletion.

Dr DIPAMA (Burkina Faso) expressed support for the work of the Secretariat. The results of a survey in 2013 to determine the burden of noncommunicable diseases had led his Government to elaborate more targeted prevention and control programmes. He supported the action plan for 2013–2020, noting that its implementation would need technical support from WHO and other partners. He drew attention to the need for relevant indicators in order to monitor and evaluate the impact of the programmes.

Sir Trevor HASSELL (Barbados) acknowledged WHO's work and consequent progress in the follow-up to the Political Declaration in 2011. The report on progress in implementing the action plan (document A67/14) would serve as a tool for planning and priority-setting from 2013 to 2020. He supported in principle the terms of reference for the Inter-Agency Task Force and noted the action plan indicators, warning, however, that resource-constrained countries might not be able to implement the plan. Strategies to support sustainable funding should therefore have been considered. He recommended further engagement of civil society in the global coordination mechanism.

Ms SOVD TUGSDELGER (Mongolia) commended the work of WHO in raising the profile of noncommunicable diseases in development work at the global level and implementing the action plan for 2013–2020. Her country had made progress, especially in tobacco control, but continued to have one of the highest age-standardized mortality rates from noncommunicable diseases. As a highly publicized but severely underfunded public health issue, noncommunicable diseases should be given priority in the United Nations Development Assistance Framework. The terms of reference for the Inter-Agency Task Force should be submitted to the United Nations Economic and Social Council. She asked the Secretariat to provide guidelines for the development of the outcome indicators and the nine voluntary global targets.

Dr FEISUL IDZWAN MUSTAPHA (Malaysia) said that implementation of many of the cost-effective interventions recommended by WHO would require legislative and regulatory changes. Regional and bilateral trade agreements presented a potential threat to the application of policy interventions, in particular in the area of diet-related health. Such trade agreements were usually negotiated through international trade ministries, and Member States' health ministries therefore

needed to advocate the importance of adopting a “health-in-all-policies” approach in order to align profit-oriented activities with public health goals. WHO should provide further leadership in public health law, beyond its achievements in tobacco control and international health regulations.

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

The meeting rose at 12:20.

SEVENTH MEETING

Thursday, 22 May 2014, at 14:40

Chairman: Dr P. RENDI-WAGNER (Austria)

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

Monitoring the achievement of the health-related Millennium Development Goals: Item 14.1 of the Agenda (Document A67/19)

- **Health in the post-2015 development agenda:** Item 14.1 of the Agenda (Document A67/20) (continued from the third meeting, section 4)

The CHAIRMAN announced that the drafting group that had been established would consider a revision of the earlier proposed draft resolution, which read:

The Sixty-seventh World Health Assembly,

PP1 Having considered the report on Monitoring the achievement of the health-related Millennium Development Goals. Health in the post-2015 development agenda;¹

PP2 Reaffirming the Constitution of the World Health Organization, 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 conditions;

PP3 Reaffirming also the principles of the United Nations Millennium Declaration adopted by the United Nations General Assembly in resolution 55/2, including human dignity, equality and equity, and stressing the need for their reflection in the post-2015 development agenda; *(taken from WHA66.11)*

PP34 Recognizing that health is ~~central to human development as both a contributor a precondition for~~ and an outcome and **indicator of all dimensions of sustainable** ~~that universal health coverage is an important measure of~~ development; *(taken from para 138 of A/RES/66/288)*

PP45 Recalling resolution WHA66.11 on health in the post-2015 development agenda, which urged Member States to ensure that health is central to the post-2015 UN development agenda;

(PP56) Reaffirming the need to sustain current achievements and accelerate efforts in those countries where more rapid progress is needed towards achievement of the health-related Millennium Development Goals;

PP97 Cognizant also of the burden of **maternal, newborn and child morbidity and mortality**, communicable diseases, **including HIV/AIDS, tuberculosis, malaria** and neglected tropical diseases and the rising burden of non-communicable diseases and injuries;

PP68 Acknowledging that universal health coverage implies that all people have access without discrimination to nationally determined sets of the needed promotive, preventive, curative, palliative and rehabilitative essential health services and essential, safe, affordable,

¹ Document A67/20.

effective and quality medicines, while ensuring that the use of these services does not expose the users to financial hardship **with a special emphasis on the poor, vulnerable and marginalized segments of the population;** (para 10 of A/RES/67/81);

PP9 Recognising that the provision of universal health coverage requires full and effective implementation of the Beijing Platform for Action,⁹ the Programme of Action of the International Conference on Population and Development⁶ and the outcomes of their review conferences, including the commitments relating to sexual and reproductive health and the promotion and protection of all human rights in this context, and emphasizes the need for the provision of universal access to reproductive health, including family planning and sexual health, and the integration of reproductive health into national strategies and programmes; *(taken from para 11 of A/RES/67/81)*

PP10 Recognising the importance of strengthening health systems and building capacities for broad public health measures, health protection and addressing determinants of health towards attaining equitable universal coverage; *(wording partially based on paras 9 and 10 of A/RES/67/81)*

PP711 Emphasizing that policies in sectors other than health have a significant impact on health outcomes, hence the need to identify synergies between policy objectives in the health and other sectors through a whole-of-government, whole-of-society and Health in All Policies approach the post-2015 development agenda;

PP812 Appreciating the need for countries to uphold the principles of country ownership and the global community to respect them;

PP13 Recognising that the multi-sectoral nature of achieving health improvement means that progress monitoring must include measuring health systems performance as well as health outcomes that capture mortality, morbidity and disability.

PP104 Recalling resolution WHA63.16 on the WHO Global Code of Practice on the International Recruitment of Health Personnel, which recognized that addressing present and expected shortages in the health workforce is crucial to protecting global health and implementing the post 2015 development agenda, **as well as other previous related WHA resolutions, and welcoming efforts made to strengthen the health workforce including the commitments made by Member States in the Recife Declaration on Human Resources for Health: renewed commitments towards Universal Health Coverage**

OPI URGES Member States¹

~~(421)~~ to engage actively in discussions on the post-2015 development agenda, respecting the process established by the United Nations General Assembly;

(42) to call for the full realization of the right to the enjoyment of the highest attainable standard of physical and mental health and to ensure that health ~~remains~~ is central to the post-2015 development agenda;

~~(2&53)~~ to ensure that the post 2015 development agenda **sustains and builds on accelerated progress towards the health-related MDGs on nutrition, child, maternal, sexual and reproductive health, HIV, tuberculosis and malaria (currently MDGs 1a, 4, 5, 5b and 6), while also addressing the burden of neglected tropical diseases (NTDs);**

~~(4) to recognize universal health coverage as a means to ensure comprehensive health services and financial risk protection as core principle of the health component in the post-2015 development agenda;~~

(4) to recognize that additional attention needs to be paid to newborn health in addressing the unfinished agenda of child health;

(5) to incorporate action to reduce preventable and avoidable burden of mortality,

¹ And, where applicable, regional economic integration organisations.

morbidity and disability related to non-communicable diseases, cancers and injuries while also promoting mental health;

(46) to recognize the importance of universal health coverage (incorporating universal access to prevention, promotion, treatment, rehabilitation and palliation) and financial risk protection as a core principle of the health component in the post-2015 development agenda;

(7) to call for a rights-based approach as a pre-condition for equitable and inclusive sustainable development;

(98) to honour their commitments towards national and international health financing in order to fully implement the post 2015 development agenda;

(109) to strengthen international cooperation in support of national, regional and global health plans and to ensure that external funds for specific health interventions are aligned with the national health priorities in the country by fully adhering the principles of aid effectiveness, and that they contribute in a predictable way to the sustainability of financing;

(10) to ensure that regular assessment of progress towards targets and accountability are integral elements of the post-2015 development agenda, including the strengthening of civil registration and vital statistics and health information systems, with disaggregated data to monitor equity;

(11) to sustain and accelerate progress on nutrition, child (particularly newborn health), maternal, sexual and reproductive health, HIV, tuberculosis and malaria, and neglected tropical diseases where appropriate;

(312) to strengthen national strategies and plans for the prevention and control for the prevention and control of non-communicable diseases including cancers, injuries and mental disorders, through the appropriate mix of health promotion, prevention, treatment, rehabilitation and palliation and Neglected Tropical Diseases;

(6&713) to develop effective and efficient health financing systems so as to raise adequate funds for health, promote risk pooling among the population prepayment for health services and strategic purchasing in order to and maintain strong health systems capable of assuring coverage and access with needed services with financial risk protection, including access to quality, safe and affordable health products, medicines, vaccines and diagnostics and other medical devices, motivated and trained human resources, appropriate infrastructure, and sustainable financing systems which avoid significant direct payments at the point of delivery and reduce catastrophic health expenditures;

(814) to adopt a multi-sectoral approach to address the social, environmental and economic determinants of health within sectors including, as appropriate, through the Health in All Policies approach, with a view to reducing health inequities and enabling sustainable development;

(115) to adopt a systematic and coordinated approach to support and adequately fund research aimed at supporting the implementation of the post-2015 development agenda to strengthen monitoring of progress and accountability through well-functioning health information systems including birth and death registration and research;

(13) to consider the inclusion of relevant health targets and indicators under relevant sustainable development goals for the post-2015 development agenda;

OP2 REQUESTS the Director-General:

(1) to continue active engagement with on-going discussions on the post-2015 development agenda, working with the United Nations Secretary-General, to ensure the centrality of health in all relevant processes;

(2) to continue to provide support to countries, upon request, in articulating their positions on health in the post-2015 development agenda;

- (3) to report to the Assembly every two years on progress on the implementation of the post 2015 development agenda as it related to health.

(For continuation of the discussion and approval of the draft resolution, see the summary record of the twelfth meeting, section 7.)

2. NONCOMMUNICABLE DISEASES: Item 13 of the Agenda (continued)

Prevention and control of noncommunicable diseases: Item 13.1 of the Agenda (Documents A67/14, A67/14 Add.1, A67/14 Add.2 and A67/14 Add.3) (continued from the sixth meeting, section 3)

Dr NAWANAN THEERA-AMPORN PUNT (Thailand) welcomed the progress achieved in implementing the action plan for 2008–2013 and in developing the two sets of terms of reference. Thailand was in the process of adopting the nine action plan indicators and would begin integrating the action plan for 2013–2020 and the action plan for prevention and control of noncommunicable diseases in the South-East Asia Region into its existing prevention and control strategies. Multisectoral actions were the key to successful prevention and control, particularly in relation to the social determinants of noncommunicable diseases.

Management of conflicts of interest should go further than the establishment of a repository to compile incidents: periodic reviews and appropriate actions must also be undertaken. Protection against the undue influence and unethical practices of industry needed collective action. He decried the use of trade agreements to restrict governmental policies for protection of the public against unhealthy products and alcohol, calling for sustained political commitment to achieve a 10% reduction in the harmful use of alcohol. Information systems had to be improved in order to monitor progress in the implementation of the action plan for 2013–2020, for which the Secretariat should provide technical support to Member States.

Ms P. GONZÁLEZ (Uruguay) said that the social and environmental determinants of health were the main focus of her Government's efforts to implement the Political Declaration, with policies directed at promoting healthy diets, physical activity and cultural and behavioural change. Substantial progress had been made in the area of tobacco control, leading to a sharp decrease in tobacco consumption among adolescents between 2003 and 2012, accompanied by a fall in rates of myocardial infarction, as a result of a comprehensive package of measures, applied across sectors with civil society involvement. Highlighting the work done by the Secretariat to achieve objective 3 of the action plan for 2008–2013, she added that the Secretariat must be encouraged to curb interference by the tobacco industry. The United Nations Inter-Agency Task Force on the Prevention and Control of Noncommunicable Diseases, which had a broader mandate than its predecessor task force on tobacco control, must maintain the momentum already generated. The Secretariat should support the establishment of national task forces. In the terms of reference for the Working Groups to be established under the global coordination mechanism work plan (document A67/14 Add.3, Annex) the nomination of members (paragraphs 3 to 6) should be amended to provide for the involvement of Member States through the regional offices. She supported the amendments proposed by the delegate of Brazil in that regard at the previous meeting.

Dr OKABAYASHI (Japan) commended the Secretariat's work to facilitate the development of the terms of reference for the global coordination mechanism and the Inter-Agency Task Force and the action plan indicators. A multisectoral approach to noncommunicable diseases was needed, and efforts must be continued to find ways to involve non-State actors while avoiding conflicts of interest under the Secretariat's leadership.

Ms YU Cheong-hee (Republic of Korea) welcomed the terms of reference for the Inter-Agency Task Force and the development of the action plan for 2013–2020, but argued for a better evaluation of implementation than occurred with the action plan for 2008–2013. Each country should develop specific goals tailored to local conditions. Her Government would consider adapting some of the action plan's proposals for its medium- to long-term strategy and would share its experience with health ministries in neighbouring countries.

Ms MASLENNIKOVA (Russian Federation) welcomed the agreement on the terms of reference of the Inter-Agency Task Force, whose strength lay in its ability to work across the organizations in the United Nations system, the World Bank and IMF. She also supported the terms of reference for the global coordination mechanism, whose management must rest with Member States, which could call on organizations in the United Nations system and intergovernmental structures, professional bodies and nongovernmental organizations. Attention should be paid to the principles of WHO's work with the private sector. Partner organizations should not have the same rights for decision-making as Member States. It would be appropriate for the prevention and control of noncommunicable diseases to be included in the post-2015 development agenda either as a single goal or as part of a goal on universal health care.

Dr CORTEZ (Philippines) called for synergistic collaboration between governments, intergovernmental organizations and non-State actors for prevention and control efforts at the global, regional and national levels. The Secretariat should continue to provide Member States with concrete guidance on ways to develop strategies for engagement with non-State actors and on the identification of areas of complementarity between such actors and governments. The Philippines was working with WHO to prepare guidelines for a voluntary healthy food certification programme, which set limits on the calorific, fat, sugar and salt content of processed foods and was studying the possibility of mandatory food labelling; Congress was considering legislation to impose a tax on soft drinks and carbonated drinks.

Dr MOHSIN (Brunei Darussalam) welcomed the work on implementing the action plan for 2008–2013. The successful launch of a national multisectoral action plan was enabling stakeholders, including the non-health sectors, to undertake sustainable action to promote healthy lifestyles and prevent noncommunicable diseases. In line with the action plan for 2013–2020, her Government had set national targets and indicators with the aim of attaining the nine voluntary global targets for noncommunicable diseases by 2025. She welcomed the expanded mandate of the United Nations Ad Hoc Inter-Agency Task Force on the Prevention and Control of Non-communicable Diseases, including the work to support accelerated implementation of the WHO Framework Convention on Tobacco Control.

Mr GULDVOG (Norway) underlined the contribution of non-State actors to preventing and controlling noncommunicable diseases, as regulatory and fiscal measures alone would be insufficient to meet the ambitious targets set for 2025. Norway was achieving positive results from its structured collaboration with civil society. Although he would have preferred a more action-oriented role for non-State actors in the global coordination mechanism, he supported its terms of reference and welcomed the proposed work plan. He noted with satisfaction that WHO had undertaken all the actions required of it in the Political Declaration. He supported the terms of reference for the Inter-Agency Task Force and the action plan indicators for 2013–2020. Norway was working with other interested Member States to ensure that noncommunicable diseases remained on the agenda of WHO's governing bodies in 2015.

Dr KIBACHIO (Kenya) welcomed the increased priority given to noncommunicable diseases in development work at the global and national levels. With regard to the terms of reference for the global coordination mechanism, the engagement of non-State actors must be subject to due diligence.

He welcomed the inclusion of national achievement-based indicators in the action plan indicators for 2013–2020 and proposed that indicators should capture the proportion of health budgets allocated to noncommunicable diseases and the extent to which the prevention and control of noncommunicable diseases was integrated with other disease control interventions.

Dr ELOAKLEY (Libya) suggested either setting up a drafting group to work on the proposed work plan for the global coordination mechanism or convening an open-ended Member State consultation after the high-level meeting of the United Nations General Assembly to be held in New York in July 2014, in order to coordinate the work plan with the vision of that meeting. He proposed the following amendments to the terms of reference for the Working Groups to be established as part of the implementation of the global coordination mechanism work plan (document A67/14 Add.3, Annex): at the end of the first sentence of paragraph 3, the words “in consultation with Member States and the regional directors” should be added, and the last sentence of paragraph 14 should be replaced with “Working group reports will be made available to the public.”

At the second regional meeting on noncommunicable diseases (Cairo, 24 and 25 April 2014), Member States from the Eastern Mediterranean Region and other stakeholders had made various recommendations, including scaling up the implementation of the commitments in the Political Declaration, strengthening national efforts to reduce the burden of noncommunicable diseases and their socioeconomic consequences, and establishing, by 2014, a high-level national, multisectoral commission, agency or task force for engagement, policy coherence and accountability of sectors beyond health, and for monitoring the implementation of a multisectoral national strategy and plan.¹

Ms USIKU (Namibia) attributed the limited progress made in most developing countries largely to limited financial and technical capacity. Many countries in the African Region, including her own, required intensive technical guidance and support to draft appropriate legislation, regulations and policies as well as a multisectoral strategy and plan for the prevention and control of noncommunicable diseases.

The four indicators 3a–3d in the action plan for 2013–2020 should be replaced with one indicator for measuring progress in the development of an integrated policy, strategy or plan on noncommunicable diseases.

Mr JARAMILLO NAVARRETE (Mexico) supported the terms of reference for the global coordination mechanism. Given the importance of the social determinants of health, which were influenced by a variety of factors including income and education, health must be placed at the centre of all public policies and priority given to cross-cutting and multisectoral approaches, measurement of impact, and accountability. For that reason, his Government had recently launched a national strategy for the prevention and control of overweight, obesity and diabetes, which focused on the promotion of healthy lifestyles, patient-centred medical care, and regulatory and fiscal measures, including taxes on highly calorific products of low nutritional value. He commended WHO’s integrated approach to smoking, alcohol consumption, sedentary lifestyles and other risk factors.

Professor FREEMAN (South Africa) congratulated the Secretariat on its success in raising the priority of noncommunicable diseases at global and country levels. Although his country faced a high prevalence of communicable diseases and maternal and child health problems, it realized that failure to act on noncommunicable diseases would have serious health, financial and development implications. South Africa had developed an ambitious five-year prevention and control strategy, and supported the inclusion of noncommunicable diseases in the post-2015 development agenda. Under South African chairmanship, the Inter-Agency Task Force was focusing on the need for a whole-of-society and whole-of-government approach to noncommunicable diseases. He supported the proposed

¹ See <http://www.who.int/nmh/events/2014/emro-ncd.pdf>.

work plan for the global coordination mechanism, as amended by the delegate of Brazil, and welcomed the nine action plan indicators for 2013–2020.

Dr AL BUSAIDI (Oman) said that its long-term plan, Health Vision 2050 Oman, was fully consistent with the Political Declaration and prioritized the control of noncommunicable diseases. He supported adoption of the nine action plan indicators for 2013–2020; Oman would report its progress to the Secretariat. Given the importance of multisectoral planning for that purpose, a national committee representing the governmental, nongovernmental and private sectors had been formed in order to elaborate a national policy for the control of noncommunicable diseases, based on the action plan for 2008–2013. In addition, Oman had increased its relevant financial and human resources and developed an epidemiological surveillance system to ensure accurate mapping.

Professor BAGGOLEY (Australia) said that Australia was committed to supporting the action plan for 2013–2020, which would build on the achievements of the previous action plan. He supported the terms of reference for the global coordination mechanism and encouraged the Secretariat to support Member States in ensuring that the mechanism's work was effectively focused and added clear value, particularly in the light of budgetary constraints. He welcomed the report of the formal meeting of Member States to complete the work on the terms of reference for the Inter-Agency Task Force and agreed that it should be forwarded to the United Nations Economic and Social Council for consideration at its meeting in June 2014. He also supported adoption of the nine action plan indicators for 2013–2020 and the United Nations General Assembly draft resolution on the scope and modalities of the comprehensive review and assessment of progress.

Dr SHAKEELA (Maldives) said that noncommunicable diseases were the leading cause of death in the South-East Asia Region, a populous region with heavy burdens of poverty and disease. Despite those constraints, the WHO regional budget allocation had been cut, which could only impede efforts to prevent and control noncommunicable diseases, with potentially disastrous implications globally. Behavioural risk factors could be controlled with the correct strategies and resources, and she called on the Inter-Agency Task Force to increase its provision of financial, technical and staffing support, in particular for implementation of the WHO Framework Convention on Tobacco Control. Notwithstanding considerable industry pressure, Maldives was aiming to implement tobacco control measures imminently. Access to diagnostic services and treatment for noncommunicable diseases would remain a challenge on account of geographical constraints. An all-embracing global solution was required. Regional and international collaboration, combined with a multisectoral approach, was essential to the achievement of the prevention and control targets.

Dr NIKEN WASTU PALUPI (Indonesia) said that, although common indicators were useful, each country should define its own targets to reflect its domestic circumstances. As a follow-up to the Political Declaration, her Government had set indicators for noncommunicable diseases in its national action plan for 2015–2019. They had been adapted from the global monitoring framework and the nine voluntary global targets under WHO's action plan for 2013–2020, and included the integrated management of risk factors, screening and monitoring. As risk factor control was more efficient and affordable than later treatment, data on risk factors obtained from routine national health surveys would be collected through the national health surveillance system. Her Government was committed to comprehensive health system strengthening; it sought to maintain and improve collaboration with non-health sectors that nonetheless influenced public health and to mobilize resources in order to improve the accessibility, affordability, reliability and quality of medicines, including traditional medicines.

Mr ZHANG Yong (China) commended the progress reported by the Secretariat and endorsed the terms of reference for both the global coordination mechanism and the Inter-Agency Task Force;

the amendments proposed by the delegate of Brazil to the latter were in principle acceptable. The action plan indicators for 2013–2020 were also acceptable.

The global public health challenge of noncommunicable diseases required WHO to continue to lead strong, effective and pragmatic action through the global coordination mechanism and the Inter-Agency Task Force in order to ensure full implementation of the Political Declaration; to develop technical tools for effective and timely monitoring, screening and intervention to reduce major risk factors; and to increase technical and financial support to developing countries. China would continue to contribute to that fight by stepping up its international and regional cooperation efforts.

Dr AL-TAAE (Iraq) urged consolidation of all activities in the global strategy for the prevention and control of noncommunicable diseases, which ought to reflect the strategic work plans of Member States, taking into consideration the social, environmental and economic determinants of health. Furthermore, all non-State actors should unify their strategic work plans at country level. In Iraq, various stakeholders, including the United Nations Development Assistance Framework, the Ministry of Health and civil society institutions, were collaborating within the primary health care context. Relevant programmes and process indicators had also been unified in the national strategic work plan under the aegis of a technical advisory group that included WHO and other partners.

Dr SEIXAS DOS SANTOS (Timor-Leste) said that his country was intensifying efforts to reduce risk factors, such as tobacco use, through legislative and fiscal policies. Notable progress had been made but serious challenges remained. Persistent interference from the tobacco, alcohol and food industries continued. Intersectoral partnerships needed to be more effective. Greater investment was required to strengthen the national health system as existing capacity and resources were insufficient to cope with the double burden of communicable and noncommunicable diseases. He called on WHO and other partners to provide coordinated technical support for the implementation of national multisectoral policies and action plans; to mobilize resources to support countries in expanding the introduction of cost-effective interventions; and to give due priority to noncommunicable diseases in the post-2015 development agenda.

He endorsed the nine voluntary global targets of the action plan for 2013–2020 and supported the terms of reference of both the Inter-Agency Task Force and the global coordination mechanism, as well as the work plan for the mechanism. The high-level meeting of the United Nations General Assembly in July 2014 would provide an opportunity to review progress, identify gaps and prioritize follow-up actions against noncommunicable diseases.

Dr TAAL (Gambia), noting with concern the rapidly increasing burden of noncommunicable diseases in the African Region, thanked WHO for spearheading the global efforts to control noncommunicable diseases and in particular the Regional Office for Africa in building capacity through the development of integrated policies and action plans and its multisectoral engagement initiative that had culminated in the first regional stakeholders' dialogue on risk factors (Johannesburg, South Africa, 18–20 March 2013). He endorsed the nine action plan indicators for 2013–2020 and the terms of reference of both the Inter-Agency Task Force and the global coordination mechanism. Recent Gambian initiatives included the establishment of a directorate of health promotion and education, and in collaboration with the WHO country office the preparation of a multisectoral action plan for the prevention and control of noncommunicable diseases.

Dr BEN SALAH (Tunisia) said that Tunisia had adopted a holistic approach to noncommunicable diseases with the overall objective of ensuring the right to health for all through universal access, better management of the social determinants of health, good governance and civic responsibility. It had initiated a participatory and inclusive dialogue involving ordinary citizens, professionals, regulators, industry leaders, experts and trade unions, through regional health meetings. The outcomes of those meetings would be considered in June 2014 by a citizens' jury and a national

conference. Such an approach facilitated the inclusion of health in all policies and the involvement of all stakeholders.

Dr SCHMIDT (Paraguay) supported the proposed action plan indicators for 2013–2020 and the priority actions recommended for Member States. Paraguay's national action plan on noncommunicable diseases for 2014–2024 had been prepared through a multisectoral and participatory approach, prioritizing four noncommunicable diseases and five risk factors. The health ministry had reinforced its management of noncommunicable diseases, involved civil society including academia and municipalities, and was increasing human resources; the role of non-State actors remained to be clarified. In response to the high prevalence of overweight and obesity found in the population, legislation had been enacted that focused on awareness-raising, prevention and treatment, in line with the national action plan and in both public and private sectors. A primary health care model had also been introduced for patients with chronic diseases. He supported the proposed terms of reference for the Inter-Agency Task Force, but emphasized the importance of transparency and representativeness of its members.

Ms VACA (Colombia) welcomed the adoption of the action plan for 2013–2020. Noncommunicable diseases, the leading cause of morbidity and mortality in Colombia, were given priority in the national public health plan 2010–2021. She supported the amendments proposed by the delegate of Brazil to the global coordination mechanism, emphasizing that experts and Working Group members should be selected from a roster prepared by Member States and that it was important to clarify the role of non-State actors. The global coordination mechanism and the Inter-Agency Task Force were expected to prevent duplication and facilitate the efficient use of resources at all levels; their success could not only improve health globally but provide a model for synergistic collaboration on other diseases.

Dr SEAKGOSING (Botswana) said that a second national survey of noncommunicable diseases using the WHO STEPS instrument would be conducted in Botswana later in 2014. He noted progress in implementing the Political Declaration, and welcomed the work plan and terms of reference for the global coordination mechanism, as well as the establishment of monitoring mechanisms, which were necessary if targets were to be attained. Success in implementing the action plan for 2013–2020 would depend on strengthened national capacity and a multisectoral approach, and the role of all partners, including non-State actors, should be clear and monitored. He called on the Secretariat to provide technical support for health system strengthening where requested.

Mr CHUAH (New Zealand) welcomed the terms of reference of the global coordination mechanism and the Inter-Agency Task Force, both of which sought to strike a balance between the productive involvement of non-State actors and the protection of WHO from inappropriate influences that could compromise its reputation and work. He welcomed the proposed work plan for the global coordination mechanism, and the amendments proposed by the delegate of Brazil to the terms of reference for the Working Groups. Significant progress had been made in New Zealand on noncommunicable diseases, but much remained to be done, including making the country smoke-free by 2025.

Mr AL MARZOUQI (United Arab Emirates) said that his country had successfully controlled many noncommunicable diseases and eradicated others through an effective national strategy, partnerships with the international community, and implementation of the global strategy for the prevention and control of noncommunicable diseases 2008–2013 in line with the Political Declaration.

Recent measures included the introduction of an early detection programme for cardiovascular disease, cancer and diabetes, for which a national control strategy for 2009–2018 was in place and access for target groups to services at all health care facilities was guaranteed through a well-resourced national diabetes programme. The national noncommunicable diseases strategy was rooted in WHO's

evidence-based guidelines and a control strategy adopted by the Arab Gulf States, and was accompanied by an operational plan that included prevention, monitoring and assessment, and community involvement. Commending the progress made in implementing the action plan for 2008–2013 and the work of the International Advisory Council of the Global Noncommunicable Disease Network, he reaffirmed support for all the proposals mentioned in the reports. He expressed appreciation of the global monitoring framework and the set of indicators.

Mr ESPINOSA SALAS (Ecuador) welcomed the report on progress and the proposed work plan for the global coordination mechanism. In Ecuador, noncommunicable diseases were a health priority; the Government had made significant investments in the social and medical sectors, especially in the areas of diet and prevention. He supported the amendments proposed by the delegate of Brazil to the terms of reference for the global coordination mechanism, emphasizing the role of Member States in selecting Working Group members.

Dr CARBONE DE FINK (Argentina), also welcoming the report on progress, emphasized WHO's functions relating to the United Nations' comprehensive review and assessment that would take place later in 2014. The global coordination mechanism would be a useful tool for the Secretariat and Member States in attaining and monitoring targets. She supported the amendments proposed by the delegate of Brazil.

Ms DOAN PHUONG THAO (Viet Nam), noting the report of the formal meeting of Member States to complete the work on the terms of reference for the Inter-Agency Task Force, agreed that it should be submitted to the coordination and management meeting of the United Nations Economic and Social Council in June 2014. She supported the proposed action plan indicators for 2013–2020, which would help to ensure that her country's first comprehensive strategy on noncommunicable diseases, including a monitoring and evaluation framework, was aligned with WHO's global action plan for 2013–2020. WHO should continue its leading role in the follow-up to the comprehensive review and assessment later in 2014.

Dr OBEMBE (Nigeria), noting the progress made in implementing the action plan for 2008–2013, said that Nigeria's first national policy and strategic plan of action for the prevention and control of noncommunicable diseases 2014–2018 was aligned with the WHO global action plan for 2013–2020. Actions in 2013 under the national policy included the "Stop Diabetes Initiative", the endorsement of national nutrition guidelines and approval of the national stroke prevention programme. Physical activity was being encouraged, with for instance the establishment of gymnasiums in workplaces. Parliament was considering legislation on tobacco control. He supported the proposed terms of reference of the global coordination mechanism.

Ms Yu-Hsuan LIN (Chinese Taipei) endorsed the terms of reference of the Inter-Agency Task Force, the amendments proposed by the delegate of Brazil to the terms of reference of the global coordination mechanism, and the action plan indicators for 2013–2020. Chinese Taipei offered further cooperation in combating noncommunicable diseases and had already achieved positive results, including a decline in adult obesity and a significant increase in physical activity, improved policies and the purchase and provision of healthy foods, enactment of legislation to restrict advertising of unhealthy food and drinks for children, an extension of the ban on smoking, and a lowering in the legal blood alcohol limit to 0.03% that had reduced deaths from drink-driving.

Ms KUSANO (International Council of Nurses), speaking at the invitation of the CHAIRMAN, commended the progress made in fulfilling commitments under the Political Declaration and expressed support for coordinated multisectoral actions through the global coordination mechanism. Investment in nursing paid dividends, especially in primary health care settings. Countries should develop national indicators to monitor the implementation of the action plan for 2013–2020, paying

particular attention to the inclusion of noncommunicable diseases in nurses' education, implementation of proven nurse-led interventions, and removal of regulatory barriers to allow nurses to assess and detect noncommunicable diseases and initiate interventions early. Nurses should be involved in policy-making and implementation of innovative solutions.

Ms SEAL-JONES (International Alliance of Patients' Organizations), speaking at the invitation of the CHAIRMAN, called for the empowerment of individuals and communities to engage in prevention and control activities, while patients were set at the centre of all strategies. The global coordination mechanism should strengthen global and regional coordination, and its objectives should be closely aligned to the action plan for 2013–2020. Its progress should be measured and reported in line with the global monitoring framework for noncommunicable diseases so as to ensure Organization-wide coherence. She supported the inclusion of non-State actors in the proposed global coordination mechanism's Working Groups, and suggested they be involved in the guidance and oversight of that mechanism. All partners should have an equal voice, including patient groups.

Dr KEENAN (International Pediatric Association), speaking at the invitation of the CHAIRMAN, noted that factors in childhood and adolescence, which were critical periods for developing lifestyles and behaviours responsible for noncommunicable diseases in adult life, required attention from governments, civil society and the private sector. He urged Member States to implement proven life-course interventions in the context of national child and adolescent health and noncommunicable disease plans; ensure paediatric access to affordable medicines; and engage children, young persons and their families in noncommunicable disease systems planning. Multisectoral responses should be expanded, especially as effective measures often required non-health-sector legislation. The needs of children and adolescents should be included in national policy planning. Social protection measures and universal health coverage would mitigate the social and financial impact of noncommunicable diseases.

Mr ADAMS (Union for International Cancer Control), speaking at the invitation of the CHAIRMAN, expressed disappointment with the proposed terms of reference of the global coordination mechanism after having provided input to the consultative process over the previous two years. The structure was not good enough and did not take into account lessons learnt from a note by the United Nations Secretary-General in 2012.¹ The global coordination mechanism did not make adequate provision for the participation of non-State actors and lacked an advisory group to provide support and guidance. The mechanism fell short of the vision and commitments of the Political Declaration; it should be strengthened after the comprehensive review and assessment to be conducted by the United Nations General Assembly.

Mr OTTIGLIO (International Federation of Pharmaceutical Manufacturers and Associations), speaking at the invitation of the CHAIRMAN, said that the current terms of reference of the global coordination mechanism were inadequate to guarantee its success. The mechanism should have had clear objectives and deliverables that were time-bound, sufficiently resourced and outcome-focused, facilitating short-term solutions to encourage further long-term involvement. Moreover, the terms of reference did not provide for the effective and valuable participation of non-State actors. Recent partnerships between international organizations and non-State actors had demonstrated the value of multistakeholder, multisectoral action. It was to be hoped that the terms of reference would be further elaborated through an inclusive consultation process.

¹ Note by the Secretary-General transmitting the report of the Director-General of the World Health Organization on options for strengthening and facilitating multisectoral action for the prevention and control of non-communicable diseases through effective partnership. United Nations General Assembly, Sixty-seventh session, document A/67/373.

Dr MOREIRA (The World Medical Association, Inc.), speaking at the invitation of the CHAIRMAN, welcomed the implementation of the action plan for 2008–2013, but expressed concern about the terms of reference of the global coordination mechanism. The rules and conditions for participation of non-State actors were unclear, as was the meaning of the term “participants”, which should be replaced by “partners” and clearly defined. The implementation of the action plan for 2013–2020 would depend on the work and commitment of health care workers at the national level. Professional associations in particular had a key role to play in the achievement of universal health coverage and the incorporation of noncommunicable diseases in the post-2015 development agenda; they too should be more clearly defined within the mechanism and differentiated from other non-State actors. The eligibility criteria, functions and expected outputs of the Working Groups should be better defined and resources should be made available to support their activities.

Ms DAIN (International Diabetes Federation), speaking at the invitation of the CHAIRMAN, said that the comprehensive review and assessment to be undertaken at the high-level meeting of the United Nations General Assembly would provide a good opportunity to take stock of progress, identify gaps, make new commitments and reinforce the priority to be accorded to noncommunicable diseases in the post-2015 development agenda. She thus called on Member States to ensure participation at the highest political level; render the comprehensive review and assessment genuinely multisectoral in terms of participation (including civil society) and outcomes; support a strong, action-oriented outcome document with specific time-bound commitments on national action; and agree to convene periodic high-level reviews on noncommunicable diseases.

Mrs MULDER (Medicus Mundi International – International Organisation for Cooperation in Health Care), speaking at the invitation of the CHAIRMAN, stressed action on the structural and social determinants of noncommunicable diseases through national and global policies to constrain advertising that was harmful to health. Industries still influenced governments’ and WHO’s decisions, and the opportunities for policies and effective regulatory strategies were shrinking rapidly, partly because bilateral and multilateral trade and investment treaties were becoming powerful tools to challenge measures designed to protect public health. She urged WHO to ensure that the proposed Inter-Agency Task Force be mandated to deal with such trade and investment issues. The Secretariat and Member States should protect themselves against the risk of improper influence being exercised by pharmaceutical companies, business groups and industry coalitions through their involvement in standard-setting and other activities that had a bearing on noncommunicable disease policy.

Mr SCHÜRMANN (International Federation of Medical Students’ Associations), speaking at the invitation of the CHAIRMAN, commended progress being made through the action plan for 2013–2020. Action needed to shift towards the national level, but some national action plans were not operational. The forthcoming comprehensive review and assessment should encourage Member States to set national targets, prepare action plans and allocate sufficient resources for their implementation. Young people were an underused resource, particularly as the four main risk factors had their roots in adolescence. As the Political Declaration had recognized the need for multisectoral action, a whole-of-government approach, and collaborative partnership, the terms of reference of the global coordination mechanism should provide for civil society participation in coordinating or advisory bodies as well as the Working Groups.

Mr DIETHELM (Framework Convention Alliance on Tobacco Control), speaking at the invitation of the CHAIRMAN, underlined the importance of multisectoral and whole-of-government action for meeting global targets for noncommunicable diseases. A basis for multisectoral action on tobacco control already existed: the WHO Framework Convention on Tobacco Control. Its Conference of the Parties should take the lead in ensuring that tobacco control continued to spearhead multisectoral action on noncommunicable diseases.

Dr CHESTNOV (Assistant Director-General) thanked delegates for their comments which would be taken into account in the Secretariat's further work. He encouraged Member States' ministers to attend the high-level meeting convened by the United Nations General Assembly, which would take place in New York on 10 and 11 July 2014.

At the request of the CHAIRMAN, Dr DOLEA (Assistant Secretary) read out the proposed amendments to the terms of reference for the Working Groups to be established in 2014 and 2015 as part of the implementation of the global coordination mechanism work plan (contained in document A67/14 Add.3, Annex). At the end of the first sentence of paragraph 3, the delegate of Brazil proposed adding the words "from a roster of experts prepared by Member States" and the delegate of Libya proposed the further addition of the words "in consultation with Member States and the regional directors". In paragraph 4, the delegate of Brazil proposed to delete the words "including the Chair" and to add a sentence at the end of the paragraph reading: "In addition, each Working Group shall be co-chaired by representatives of two Member States, one from a developed country and one from a developing country, to be appointed in consultation with Member States." The delegate of Brazil proposed adding a sentence at the end of paragraph 11, to read: "A briefing to Member States will be held after each meeting of the Working Groups." In paragraph 13, the delegates of Greece and Brazil proposed that the words "as observers" be deleted. The delegate of Greece proposed that the deleted words be replaced by "for consultation", while the delegate of Brazil proposed that the words "for consultation" either replace the deleted words or be inserted between the words "may be invited" and "by the WHO Secretariat". The delegate of Greece further proposed the insertion of the standard footnote on non-State actors, as reproduced in footnote 2 to paragraph 5, Appendix 1 of the Annex to document A67/14 Add.1, which read: "Without prejudice to ongoing discussions on WHO's engagement with non-State actors, the engagement with non-State actors will follow the relevant rules currently being negotiated as part of WHO reform and to be considered, through the Executive Board, by the Sixty-seventh World Health Assembly. This footnote applies throughout the text where non-State actors are mentioned." The delegate of Libya proposed that the last sentence of paragraph 14 should be deleted and replaced with a sentence reading: "Working Group reports will be made available to the public."

Dr ELOAKLEY (Libya) said that he would withdraw his proposed amendment to paragraph 3 if the amendment to that paragraph proposed by the delegate of Brazil was accepted. He also wished to revise the wording of his proposed amendment to paragraph 14, to read: "Working Group reports will be made available to Member States."

The CHAIRMAN took it that the Committee wished to accept the proposed amendments.

It was so agreed.

The CHAIRMAN took it that the Committee wished to approve the nine indicators for the WHO global action plan for the prevention and control of noncommunicable diseases 2013–2020, as contained in Annex 4 and its Appendix to document A67/14.

It was so agreed.

The CHAIRMAN took it that the Committee wished to recommend the submission of the terms of reference of the United Nations Inter-Agency Task Force on the Prevention and Control of Non-Communicable Diseases to the coordination and management meeting of the United Nations Economic and Social Council, as proposed in paragraph 17 of document A67/14.

It was so agreed.

The CHAIRMAN took it that the Committee wished to endorse the terms of reference of the global coordination mechanism on the prevention and control of noncommunicable diseases, as recommended in paragraph 8 of the Annex to document A67/14 Add.1.

It was so agreed.

The CHAIRMAN took it that the Committee wished to note the proposed work plan for the global coordination mechanism on the prevention and control of noncommunicable diseases covering the period 2014–2015, including the terms of reference of the Working Groups of the global coordination mechanism, as recommended in paragraph 5 of document A67/14 Add.3, with the proposed amendments.

It was so agreed.

The CHAIRMAN informed the Committee that, as requested, the Director-General would report back to the Sixty-eighth World Health Assembly on the role of WHO in the follow-up to the high-level meeting of the United Nations General Assembly, which would take place in July 2014.

The meeting rose at 16:50.

EIGHTH MEETING

Friday, 23 May 2014, at 09:40

Chairman: Dr P. RENDI-WAGNER (Austria)

1. FOURTH REPORT OF COMMITTEE A (Document A67/68)

Dr MBUGUA (Kenya), Rapporteur, read out the draft fourth report of Committee A.

The report was adopted.¹

2. NONCOMMUNICABLE DISEASES: Item 13 of the Agenda (continued)

Disability: Item 13.3 of the Agenda (Document A67/16)

The CHAIRMAN drew attention to a draft resolution proposed by the delegation of Ecuador, which read:

The Sixty-seventh World Health Assembly,

Having considered the *World Health Organization report on disability* from 2011, the Secretariat report (document A67/16) and the draft *World Health Organization global disability action plan 2014–2021: better health for all people with disability*,

1. ADOPTS the *World Health Organization global disability action plan 2014–2021: better health for all people with disability*, attached to document A67/16;
2. URGES Member States to implement the proposed actions for Member States in the *World Health Organization global disability action plan 2014–2021: better health for all people with disability*, adapted to national priorities and specific contexts;
3. INVITES international, regional and national partners to implement the necessary actions to contribute to the accomplishment of the three objectives of the *World Health Organization global disability action plan 2014–2021: better health for all people with disability*;
4. REQUESTS the Director-General to implement the actions for the Secretariat in the *World Health Organization global disability action plan 2014–2021: better health for all people with disability* and to submit reports on the progress achieved in implementing the action plan, through the Executive Board, to the Seventy, and Seventy-fourth World Health Assemblies.

¹ See page 347.

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

<p>1. Resolution Global disability action plan 2014–2021: better health for all people with disability</p> <p>2. Linkage to the Programme budget 2014–2015 (see document A66/7 http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_7-en.pdf)</p> <p>Category: 2. Noncommunicable diseases</p> <p>Programme area: Disabilities and rehabilitation Outcome: 2.4 Outputs: 2.4.1</p> <p>How would this resolution contribute to the achievement of the outcome(s) of the above programme area(s)?</p> <p>The resolution promotes the adoption of the WHO global disability action plan 2014–2021, which specifies actions for Member States, the Secretariat and partners to support the achievement of outcome 2.4, drawing on evidence of “what works”.</p> <p>Does the programme budget already include the outputs and deliverables requested in this resolution? (Yes/no)</p> <p>Yes – if current budget trends continue through to 2021.</p>	<p>3. Estimated cost and staffing implications in relation to the Programme budget</p> <p>(a) Total cost</p> <p>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).</p> <p>(i) Eight years (covering the period 2014–2021)</p> <p>(ii) Total: US\$ 39.8 million (staff: US\$ 19.9 million ; activities: US\$ 19.9 million)</p> <p>(b) Cost for the biennium 2014–2015</p> <p>Indicate how much of the cost indicated in 3(a) is for the biennium 2014–2015 (estimated to the nearest US\$ 10 000).</p> <p>Total: US\$ 7.75 million (staff: US\$ 3.50; activities: US\$ 4.25)</p> <p>Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant.</p> <p>All levels of the Organization.</p> <p>Is the estimated cost fully included within the approved Programme budget 2014–2015? (Yes/no)</p> <p>Yes.</p> <p>If “no”, indicate how much is not included.</p>
<p>(c) Staffing implications</p> <p>Could the resolution be implemented by existing staff? (Yes/no)</p> <p>No. Additional staff are required at headquarters and in four regional offices. Recruitment for key posts will take place in this biennium.</p> <p>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.</p> <p>One full-time focal point per regional office is required in the regional offices for Africa, South-East Asia, Europe and the Eastern Mediterranean.</p> <p>Three technical officers are required at headquarters, each one leading on one of the three objectives of the plan: health, rehabilitation or data.</p>	

4. Funding

Is the estimated cost for the biennium 2014–2015 indicated in 3 (b) fully funded? (Yes/no)

No – just under 50% of funds are available.

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

Funding gap: US\$ 4 million. This funding gap will be tackled through the Organization-wide coordinated resource mobilization plan to deal with funding shortfalls in the Programme budget 2014–2015.

Dr EVANGELISTA (Philippines) recommended the adoption of the draft WHO global disability action plan 2014–2021. His Government recognized its responsibility as a Member State to contribute to the achievement of the plan’s objectives. Activities had already been undertaken to that end, including: revision of the relevant administrative order governing implementation of the national Health and Wellness Programme for Persons with Disabilities in order to focus on the three objectives of the draft action plan; a strategic plan (2013–2017) on the health of persons with disabilities, which, inter alia, aimed to increase access to health services, improve rehabilitation services and improve the quality of data on disability; and the creation and use of an online registry of persons with disabilities. He requested the Secretariat to develop standard definitions for different types of disability, particularly with regard to conditions resulting from chronic illnesses.

Mrs DE CARVALHO (Angola), speaking on behalf of the Member States of the African Region and expressing appreciation of the consultative process for the action plan, emphasized tackling the causes and consequences of disabilities, particularly given their impact at the individual, family and community levels and significant social and economic burden on countries with limited resources. Despite progress in decreasing the incidence of some disabilities, most African countries continued to face a double burden of disabilities resulting from both communicable and noncommunicable diseases. The number of road traffic injuries, a major cause of disability, had grown exponentially in many countries, and the numbers of persons suffering from physical impairments or mental disorders as a result of conflicts and terrorist activities had also risen in many parts of the Region.

Attitudes towards disability were beginning to change in the Region, particularly in urban areas and among young people, and there was increasing pressure on health and social services to offer improved facilities and assistance to persons with disabilities. The multidimensional challenge required a multisectoral approach, with expansion of low-cost interventions and particular attention to removing barriers linked to gender and discrimination. The strategy of mainstreaming disability-related interventions into all relevant health and social programmes was well adapted to the conditions and resource constraints in the Region. She endorsed the vision, goal, and objectives of the draft action plan and supported its adoption, recognizing, however, that it would have to be tailored to diverse local contexts. She encouraged partners at the national, regional and international levels to take note of the draft action plan and incorporate disability-related interventions into their strategies and country support.

Dr BRYANT (Australia) said that Australia was pleased to have contributed to the development of the draft action plan and supported its adoption. Persons with disabilities should be included in and able to benefit from efforts to improve health care services around the world. Australia was committed to working with governments in the Indo-Pacific region to ensure that the development assistance that it provided was accessible to persons with disabilities. She sought assurance that the reporting requirements for the draft action plan would complement, and not duplicate, reporting requirements under the United Nations Convention on the Rights of Persons with Disabilities.

Dr GREGORICH-SCHEGA (Austria) welcomed the specific attention given in the draft action plan to women, girls and children with disabilities and the multiple references to the need to improve statistical coverage. The draft action plan was ambitious and would be an important international tool that would support Member States' disability policies; it could also be used as a model for action on other issues. She supported the adoption of the draft action plan.

Mrs SOEKHOE (Suriname), speaking on behalf of the Union of South American Nations, said that the adoption of the draft action plan would provide an excellent opportunity to ensure that persons with disability could enjoy their fundamental right to health. A disproportionate number of people in the world living with disability were women and children in middle-income countries. As shown by the *World report on disability*,¹ the main obstacles that needed to be overcome related to education, labour market inclusion, access to health care, legislation and lack of information, the latter being a significant impediment to decision-making and implementation of public policy. She welcomed the inclusion of more success indicators in the draft action plan, which should enable better assessment of the attainment of the proposed objectives. The focus on universal health coverage, development of health policies, support for strengthening the leadership of health ministries, the provision of financial and technical support, data collection and research was laudable. Especially important was the promotion of the involvement of persons with disabilities and civil society organizations in the development of public policy. She urged the Health Assembly to adopt the draft resolution.

Mr CAMACHO (Ecuador) said that the broad consultation leading to the development of the draft action plan had been a democratic process that gave the action plan greater legitimacy. Member States had demonstrated strong political will to overcome the barriers highlighted in the *World report on disability*¹ and would surely continue to demonstrate the same commitment in implementing the action plan and seeking to ensure the full social inclusion of persons with disabilities. As disability was both a human rights issue and a development priority, Member States must take steps to uphold the rights of persons with disabilities, a group that had historically been excluded from public policies, and to improve their health and enable them to reach their full potential. Ecuador strongly supported the vision and objectives of the draft action plan and urged Member States to adopt it.

Ms SALAZAR-GONZÁLEZ (Costa Rica) said that, as a result of its ratification of the United Nations Convention on the Rights of Persons with Disabilities, Costa Rica had a strong legal framework in place that would facilitate its implementation of the draft action plan. However, it required support to strengthen regulatory systems and thus ensure access to high-quality health services for persons with disabilities. She supported adoption of the draft action plan.

Ms SINGH (South Africa), noting the broad consultations leading to the draft action plan, expressed support for the plan's adoption and welcomed its close alignment with the Convention on the Rights of Persons with Disabilities and the outcome document of 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.² The manifold burden of disease faced by her country had the potential radically to increase the prevalence of disability. As South Africa was a developing country, it would have to balance the allocation of funding between expensive rehabilitation services for persons with disabilities and preventive strategies, particularly as most disabilities could be prevented.

¹ World Health Organization, World Bank. *World report on disability*. Geneva: World Health Organization; 2011.

² United Nations General Assembly resolution 68/3.

Dr SIMA (Ethiopia) said that her Government recognized the burden and challenges of disability and its social and economic impact, which could compromise the progress made in Ethiopia in the previous two decades. She endorsed the draft action plan, which was in line with national objectives.

Ms KAMPF (United States of America) commended the Secretariat's work in producing a comprehensive draft action plan that took into account feedback from Member States and was aligned with key disability- and human rights-related principles. She supported the draft resolution and thanked Ecuador for its leadership.

Mr TALUKDER (Bangladesh) said that his Government had prioritized prevention of disability. Legislation had been enacted the previous year and diagnostic and curative services for major disabilities had been made available at primary and secondary care levels. Recent studies had shown that hearing and vision impairments accounted for a substantial proportion of disability cases in Bangladesh, and he therefore suggested that such disabilities should be given more attention in the draft action plan.

Dr USHIO (Japan), expressing support for the draft resolution, observed that the draft action plan clearly responded to a need, given the rising prevalence of disability. Japan had introduced reforms in its domestic legislation since signing the Convention on the Rights of Persons with Disabilities, which it had ratified in January 2014, and would continue pursuing initiatives aimed at enabling persons with disabilities to realize their rights. It had also provided technical cooperation on disability-related issues in many countries and would be pleased to share the results of its cooperation.

Dr FEISUL IDZWAN MUSTAPHA (Malaysia) commended the draft action plan's encouragement of a culturally appropriate, person-centred, multisectoral approach, including community-based rehabilitation, and supported adoption of the draft resolution. His Government had recognized that a life-course approach and the achievement of universal health coverage were essential and had integrated rehabilitation services into its primary care services. The development of its national action plan on health care for persons with disabilities 2011–2020 had been guided by the provisions of the Convention on the Rights of Persons with Disabilities.

Ms GOMES (Brazil) said that her country's contribution to developing the draft action plan, whose adoption she supported, had included national-level consultations with stakeholders. Brazil particularly welcomed its focus on community-based rehabilitation, which provided an operational method for ensuring respect for human rights through a multisectoral and participatory approach. However, the community-based method and the rest of the draft action plan would have to be adapted to local situations. Brazil had extensive experience in participatory community-based approaches to health care and was willing to share its experience with other countries.

Dr AL-TAAE (Iraq), expressing support for the draft resolution, said that more should be done to prevent and control disability through: the integration of prevention activities into all strategic work plans on reproductive health, communicable and noncommunicable diseases, nutrition and emergency preparedness and response; intersectoral collaboration and community participation within primary health care activities; the inclusion of prevention activities in initiatives aimed at achieving the Millennium Development Goals; the improvement of neonatal and perinatal screening and care; increased advocacy and social mobilization aimed at promoting healthy lifestyles; and appropriate and well-coordinated rehabilitation programmes that included psychosocial support for persons with disabilities.

Professor CHOMBA (Zambia) said that, although legislation of disability had been enacted in 2012, more research was needed to determine the burden of disability in Zambia in order to shape

responses appropriately. Zambia required technical support to implement its national action plan on disability. She endorsed the draft action plan.

Dr ZHOU Jun (China), acknowledging the Secretariat's work, said that disability needed collaboration between multiple organizations and sectors in order to ensure access to health and rehabilitation services for persons with disabilities. China supported the draft action plan and the draft resolution.

Mr SONG Young-jo (Republic of Korea) endorsed the draft action plan, which was in line with his Government's policies on disability. A priority was to establish goals and action plans for both avoiding disabilities and preventing deterioration of a moderate disability. The International Classification of Functioning, Disability and Health should be adapted to reflect differences in the cultural, social and economic situations of Member States, which had resulted in different definitions of disability and different disability-related policies. Discussions were needed to find practical ways to harmonize international and national definitions.

Dr PRIHARUM MARLINA (Indonesia), expressing support for the draft resolution and draft action plan, said that Indonesia had ratified the Convention on the Rights of Persons with Disabilities and was fully committed to including disability issues in its national development priorities. Disability had been incorporated into national health research activities and the International Classification of Functioning, Disability and Health criteria and the WHO Disability Assessment Schedule 2.0 were used. The Government was committed to providing early detection services and an effective referral system for persons with disabilities as well as support for their family members. Activities were ongoing in collaboration with civil society in rural areas to promote public awareness of the rights and needs of persons with disabilities. Indonesia was formulating a national work plan for people with disability that would integrate various existing health programmes and be in line with WHO's draft action plan. Technical support would be needed from the Secretariat.

Dr LAHLOU (Morocco) said that his Government recognized disability and persons with disabilities as a national health priority and as a human rights matter. Morocco was a party to all relevant United Nations conventions, and had worked to translate them into practice through appropriate laws, strategies and programmes. The country's new Constitution also made provision for public policy-making in favour of special-needs groups. With support from international partners, Morocco was strengthening its programmes by conducting studies on disability and its causes and prevention. It fully supported the draft action plan and would work to tailor it to its own specificities. The Secretariat should: standardize disability-related concepts and definitions to facilitate optimal implementation of the draft action plan; further emphasize the human rights-based approach to strategic planning in the area of disability; and review the approach to prevention, which must be the mainstay of efforts to reduce disability and a key component of any action plan.

Dr SUTHAT DUANGDEEDEN (Thailand) said that, as the draft action plan was the first of its kind related to disability, lessons must be learnt from its implementation. Successful implementation would require a change in thinking so that persons with disabilities were seen as an asset to society, not a burden. With accessible, good-quality rehabilitation services and access to the labour market, persons with disabilities could contribute as much to the development of society as anyone else, and the cost of providing improved services would be an investment with clear social and economic returns. The global shift toward universal health coverage provided a significant opportunity to change ideas and invest more in improving the quality of life of persons with disabilities and strengthening the capacity of health systems for rehabilitation; the package of benefits should be comprehensive and include health promotion, disease prevention, curative care, rehabilitation services and palliative care. He encouraged Member States to include persons with disabilities in the process of formulating the relevant policies, strategies and action plans.

Dr SUNDARANEEDI (Trinidad and Tobago) said that his country had introduced a policy on persons with disabilities, which recognized that such people had the same rights as all other citizens and should enjoy equal access to all services. The draft action plan recognized the challenges faced by persons with disabilities, particularly in access to health care; as it was guided by the Convention on the Rights of Persons with Disabilities, it presented a rights-based approach to health care. Multisectoral collaboration was essential in order to meet the needs of persons with disabilities; such collaboration could best be achieved through community-based rehabilitation, the aim of which should be to empower persons with disabilities and their families.

Dr PRASAD (India) said that his country had recognized disability as a national public health issue, a human rights issue and a development priority. It had legislation and policies to help persons with disabilities to overcome the barriers that they faced and to provide them with equal opportunities, protect their rights and enable their full participation in society. The draft action plan offered Member States crucial guidance for translating existing disability-related policies and legislation into a national action plan. His Government was already taking a multisectoral approach, with practical coordination and implementation mechanisms in place between the relevant bodies responsible for the provision of health care, rehabilitation and other services for persons with disabilities. It was also encouraging collaboration among persons with disabilities, their organizations and communities, government departments and nongovernmental organizations to ensure access to education, employment and health and social services. India would undertake the necessary activities in order to fulfil the monitoring and reporting requirements of the draft action plan.

Mrs TYSON (United Kingdom of Great Britain and Northern Ireland) said that her Government was committed to achieving full equality and inclusion for persons with disabilities and was implementing a strategy to improve their lives, the provisions of which were in line with the draft action plan. One aim of its social policy was to put persons with disability in control of their lives through promoting their well-being. Her Government's international development programmes in Africa and Asia focused strongly on aspects of disability, such as ensuring access to facilities and preventing avoidable blindness. She endorsed the draft action plan.

Dr ISMAIL (Brunei Darussalam) said that his country's strong commitment to improving the lives of persons with disabilities meant ensuring their access to health services and advocating their rights. Success needed a multisectoral approach, with the collaboration of governmental and nongovernmental partners and communities. Rehabilitation services needed to be improved through training health workers to be able to provide comprehensive services and by strengthening points of contact with care, including primary health care facilities. Legislation on disability was being reviewed with a view to enhancing the rights and benefits of persons with disabilities, their families and their carers. High quality data, particularly on epidemiological aspects and psychosocial and cultural factors relating to disability, were essential. He supported the adoption of the draft action plan.

Ms FERNÁNDEZ DE LA HOZ ZEITLER (Spain), expressing support for the draft action plan and appreciation for the leadership shown by Ecuador, said that the plan marked a significant step forward with regard to the rights of persons with disabilities. Improving their health meant improving access to health and social services. The concept of accessibility comprised multiple elements, including good communication with patients and the application of a gender perspective that took into account the specific needs of women and girls with disabilities. In 2013, Spain had consolidated its disability-related legislation in order to ensure equal opportunities for persons with disabilities in all spheres, including health care, education and employment. Approval of a plan of action for implementing Spain's strategy on disability was imminent; its measures were in line with those contained in WHO's draft action plan.

Ms RIOS (Argentina), voicing support for the draft resolution, said that work on rehabilitation was a priority area in her country's health agenda. Her Government was introducing measures to benefit persons with disabilities and protect their rights and was committed to putting in place a network of social organizations to facilitate their timely access to high-quality services. Through a multisectoral approach it was building physical and social environments, including work, schools and towns, that were suited to the needs of persons with disabilities. With regard to the draft action plan, governance, capacity-building, funding, comprehensive health care, multisectoral collaboration and a multidisciplinary approach were cross-cutting aspects of all the proposed activities. Prevention, early detection and timely intervention should be key objectives of the draft action plan, which should have success indicators for all actions and a system for reporting on progress. Argentina was committed to implementing the draft action plan, which was in line with its public and institutional policies on disability.

Dr GALVEZ (Panama) said that Panama supported and wished to cosponsor the draft resolution. As a State Party to the United Nations Convention on the Rights of Persons with Disabilities, it was already implementing a national strategy and action plan that was in keeping with the draft global action plan. A national survey on disability had shown that one in three persons had some sort of disability, with a higher proportion in rural areas and among indigenous people. He welcomed the inclusion of the vision of universal health coverage, the human rights-based focus, and the principle of evidence-based practice in the draft action plan.

Mr FLORENTÍN GÓMEZ (Paraguay) expressed support for the rights-based draft action plan and welcomed the consultative approach to its preparation, its emphasis on intersectoral action and local empowerment and on decision- and policy-making based on statistical data and research. Above all, he valued the plan's person-centred approach and focus on the rights of persons with disabilities and on the State's role as the guarantor of those rights.

Ms IBRAHIM (Maldives), welcoming the draft action plan's recognition of disability as a public health issue, a human rights issue and a development priority, said that the Secretariat should strengthen its efforts to encourage the translation of that vision into the development of relevant national policies. Persons with disabilities faced unmet health care needs and potentially worse health outcomes than other members of the population. Maldives had national legislation and a national policy on disability aimed at protecting the rights of persons with disability and ensuring their access to services, but many continued to face barriers to attaining their basic rights and freedoms, particularly with respect to health care and education and in locations outside the capital city. The Government was designing a community-based rehabilitation model in order to reach people in remote communities. Implementation of the draft action plan would help to improve the health of persons with disabilities and ensure that they lived in dignity.

Dr DIACK (Senegal), noting that his Government's approach to disability was consistent with that of the draft action plan, recalled that in 2006 the country had introduced a national community-based rehabilitation programme to promote inclusive socioeconomic development at the local level for persons with disabilities. The programme had included a social protection system that provided persons with disabilities with numerous benefits, including health care. In 2014, the Government intended to enrol 20 000 persons with disabilities into mutual health organizations, which would enable them to receive care free of charge. A digital information system would facilitate management of that programme and the creation of a database on disability. The Government would mobilize some funding for the programme, but international cooperation would also be needed.

Dr COITIÑO (Uruguay), expressing appreciation for Ecuador's leadership, highlighted an aspect that had not received much attention in the discussions, namely that around 50% of disabilities were acquired at birth and of that proportion 30% to 35% were inherited. Uruguay was undertaking

joint activities with other countries in the Region of the Americas to implement the recommendations of resolution WHA63.17 on birth defects. The health ministers of the member countries of the Southern Common Market (MERCOSUR) had approved a regional strategy on birth defects that was aligned with the draft action plan. Adoption of the action plan would provide an opportunity to coordinate activities on disability and birth defects, including those urged in resolutions WHA63.17 and WHA66.9, and to respond to the issues at the global and regional levels.

Mr PAK Jong Min (Democratic People's Republic of Korea), expressing support for the draft action plan, said that across the world persons with disabilities continued to experience difficulties accessing medical services, and programmes were needed in order to meet their health needs. Legislation had been adopted in his country to provide a legal framework for protection of the rights, interests and health of persons with disabilities and to ensure an enabling environment for their equal participation in society. The Korean Federation for the Protection of the Disabled provided rehabilitation and health care services, vocational education and labour opportunities for persons with disabilities, and various sporting events were being organized to celebrate the International Day of Persons with Disabilities.

Dr Kuy-Lok TAN (Chinese Taipei) said that, in order to improve access to health services for persons with disabilities, Chinese Taipei had enacted legislation on protection of their rights. Since 2012, the act had mandated that assessment for eligibility for social welfare benefits and services for such persons be determined on the basis of the International Classification of Functioning, Disability and Health. A centre had been established to improve the accessibility and quality of assistive technologies. Use of the Classification's codes had generated valuable data for policy-makers, particularly for decisions about allocation of social welfare and medical resources for persons with disabilities. Chinese Taipei was willing to share its experiences with others.

Ms NAUGHTON (CBM), speaking at the invitation of the CHAIRMAN, said that her organization had participated in the consultative process. The draft action plan paved the way for implementing the recommendations of the *World report on disability*, the high-level meeting of the United Nations General Assembly on disability and development, and the Convention on the Rights of Persons with Disabilities, and would provide clear guidance for global health and development efforts in the context of the post-2015 development agenda. Adequate funding of the Secretariat and national ministries, departments and community-level entities would be crucial to its success. Staff with regional and national knowledge ought to assist in the implementation of standards and provide advice about local conditions. More investment was needed in community-based rehabilitation to make it a reality in low-resource settings.

Mr MONSBAKKEN (Rehabilitation International), speaking at the invitation of the CHAIRMAN, welcomed the draft action plan, which addressed the lack of access to basic health services for people with disabilities. It represented a first significant step in enabling people with disabilities to enjoy their right of access to health care on an equal basis with others. Monitoring and reporting systems at both national and international levels were essential, and the plan's strong focus on rehabilitation and assistive technologies was welcome. The plan should also underscore disability-inclusive disaster risk reduction and have a sharper focus on women and girls with disabilities, as they often suffered double discrimination. A gender perspective should be included in every aspect of the plan.

Mr DUTTINE (Handicap International Federation), speaking at the invitation of the CHAIRMAN on behalf of World Confederation for Physical Therapy, highlighted the crucial role of physical therapists and other rehabilitation professionals in ensuring the success of national disability strategies and the achievement of universal health coverage. Rehabilitation professionals helped to reduce the prevalence and severity of disability through health promotion, disease prevention, treatment and rehabilitation measures and, as they practised in health, education, labour and other settings, contributed significantly to a multisectoral approach. In support of the draft action plan, the World Confederation for Physical Therapy was collecting data on policies, guidelines and strategies used by its members, undertaking a project on access for people with disabilities to professional training and employment in physical therapy, offering courses on collection and use of data on human functioning and promoting the use of WHO's International Classification of Functioning, Disability and Health.

Professor IMAMURA (International Society of Physical and Rehabilitation Medicine), speaking at the invitation of the CHAIRMAN, strongly supported the draft action plan, underlining the need to strengthen rehabilitation services at all levels of the health care system; develop a sustainable workforce, particularly in low-income countries; coordinate data collection and research on disability, including outcome studies on interventions, services and the supply of assistive devices; and involve people with disabilities in decision-making processes. Her organization pledged to assist in realizing the goal and objectives of the plan.

Ms HAMILTON (The Royal Commonwealth Society for the Blind (Sightsavers)), speaking at the invitation of the CHAIRMAN, said that the draft action plan was a road map for inclusion and should complement other relevant plans. Her organization looked to the Secretariat to provide support and technical guidance to Member States in implementing the action plan and to Member States and all health partners to champion disability-inclusive health policies and programmes and to ensure the engagement of people with disabilities in decisions that affected their health. The success of the action plan would hinge on commitment to overcoming barriers that impeded access to health services for persons with disabilities, such as lack of information, inaccessibility of services, stigmatization and discrimination. All parties should work to ensure that all health services were affordable and accessible for people with disabilities.

Dr CHESTNOV (Assistant Director-General) thanked delegates for their comments in support of the draft action plan, whose adoption would be an historic achievement, and the Member States that had held or helped to finance the regional consultations. The action plan would be an excellent tool for enabling the Secretariat, Member States and partners to scale up and better coordinate efforts to improve the health of persons with disabilities, which would be extremely important in the context of the post-2015 development agenda and efforts to achieve universal health coverage, including access to rehabilitation services. The Secretariat looked forward to working with Member States, nongovernmental organizations and people with disabilities in implementing the action plan.

The draft resolution was approved.¹

Comprehensive and coordinated efforts for the management of autism spectrum disorders:
Item 13.4 of the Agenda (Documents A67/17, A67/17 Add.1 and EB133/2013/REC/1, resolution EB133.R1)

Professor HALTON (Australia, representative of the Executive Board), said that the Board, at its 133rd session, had considered an earlier version of the report contained in document A67/17.

¹ Transmitted to the Health Assembly in the Committee's fifth report and adopted as resolution WHA67.7.

Member States had expressed strong support for scaling up efforts to strengthen countries' capacity to respond to the needs of persons with autism spectrum disorders and their families. It had been suggested that the report should clarify the alleged association between vaccines and autism spectrum disorders. The Board recommended that the Health Assembly adopt the draft resolution contained in resolution EB133.R1, which included various amendments proposed by Board members.¹

Dr AL HAJERI (Bahrain) affirmed that autism spectrum disorders imposed a considerable emotional and economic burden on families. Caring for children with such disorders was demanding, especially in contexts where access to services and support was inadequate. Increased international awareness of such disorders would afford greater opportunity to persuade governments and partners to provide more support for the care of persons with any sort of mental health disorder. It was also important to strengthen the efforts of all partners at country level, given that the responsibility of caring for those with autism extended beyond health ministries to other ministries and civil society organizations. Capacity-building for service providers and public awareness-raising were similarly important. She concurred with the proposed priorities for national action and supported the draft resolution.

Mr RUIZ MATUS (Mexico) said that Mexico recognized the importance of the early detection of possible developmental disorders in children and was implementing relevant strategies to that end. In recent years, the Government had incorporated comprehensive care of autism spectrum disorders into the work of the principal public health care institutions. It recognized the need to strengthen its collaboration with civil society organizations, given the complexity of the care required for persons with autism spectrum disorders. He called on the Secretariat to provide technical support to Member States for the implementation of the recommendations put forward in document A67/17.

Ms GOMES (Brazil) welcomed the Secretariat's efforts to raise awareness of, and encourage research and data collection on, autism spectrum disorders and affirmed her country's commitment to provide care and support for persons with such disorders, with respect for their autonomy and human rights. Responses needed to be based on the cross-cutting principles of universal access, respect for human rights, evidence-based practice, multisectoral action and, especially, the empowerment of those with autism spectrum disorders and their families. It was important, in that regard, to recognize the contribution that those affected could make to domestic labour forces and to encourage their inclusion and participation in society. She welcomed the draft resolution and called on the Secretariat to work with Member States to strengthen responses to and research on autism spectrum disorders.

Ms VACA (Colombia) welcomed the attention being given to autism spectrum disorders, noting that, although they were mentioned in other international instruments relating to disability, it was important to develop specific, coordinated responses to meet the needs of people with such disorders and their families. To ensure effective responses, guidance on early detection, care and rehabilitation should be developed and appropriate training should be provided for health workers. In addition, strategies for promoting the social inclusion of persons with autism spectrum disorders should be formulated and research leading to better understanding of the condition should be encouraged. Member States should share their successful experiences in order to improve the information and tools available for responding effectively to persons with autism spectrum disorders.

¹ See summary records of the third meeting, section 3 of the Executive Board at its 133rd session (document EB133/2013/REC/1).

Ms KAMPF (United States of America) said that support for people with autism spectrum disorders should be integrated into comprehensive programmes covering all disabilities or mental health disorders, without distinction or discrimination. The draft resolution made it clear that no scientific data supported the association of autism with childhood vaccination.

As there was evidence that some people diagnosed with autism spectrum disorders in childhood eventually functioned in a manner similar to people who had experienced typical development, the word “lifelong” should be deleted from the sixth preambular paragraph of the draft resolution and “and conditions that emerge in early childhood, and, in most cases, persist throughout the lifespan” should be inserted after “developmental disorders”. In the same paragraph, the words “markedly abnormal or” and “significantly” should be deleted before “impaired development” and “restricted repertoire”, respectively, reflecting the fact that autism spectrum disorders encompassed a broad range of abilities and impairments, and the phrase “with or without accompanying intellectual and language disabilities” should be inserted after “interest” and “on the developmental level and chronological age of the individual” should be replaced with “in terms of combinations and levels of severity of symptoms”. In the eighth preambular paragraph, the words “about the rising number of identified individuals with autism spectrum disorders and other developmental disorders” should be deleted; the statement was confusing as identification of the disorder, especially early identification, was critical to helping people. In subparagraph 1(1) the word “special” should be replaced with “specific”.

Dr ALQABANDI (Kuwait) said that autism spectrum disorders were a major public health challenge for her country and others and imposed an economic, social and professional burden on the public sector and civil society. Kuwait supported the comprehensive and coordinated efforts for the management of such disorders and was already working to raise awareness of them and ensure early diagnosis in order to facilitate early intervention and treatment. Obstacles included the continually growing number of cases and the lack of capacity at treatment facilities, which led to delays in starting treatment, thus giving rise to complications. Kuwait had enacted a disability law in 2010 which covered all disabilities and safeguarded the right of those with autism spectrum disorders to preventive, medical, psychosocial and rehabilitative care, education, housing, transport and employment.

Dr AL-TAAE (Iraq), supporting the draft resolution, said that autism spectrum disorders should be incorporated into primary mental health care, under the framework of prevention and control of noncommunicable diseases. Early detection of and response to such disorders should be facilitated through reproductive and maternal health services and through the education of families and the promotion of good family health practices, including monitoring children for any sign of behavioural changes. Intersectoral collaboration was needed for the effective management of autism spectrum disorders; social workers, in particular, should be involved in prevention through awareness-raising and communication with families so that the latter better understood child psychology and behavioural changes and were better informed about how to respond to and treat their children. Governments and civil society organizations should collaborate on rehabilitation programmes with a view to ensuring the swift and effective social integration of people with autism spectrum disorders.

Ms CHASOKELA (Zimbabwe), expressing support for the draft resolution, said that it was essential for all Member States to raise awareness about autism spectrum disorders. In Zimbabwe, events led by civil society and health professionals had been held on World Autism Awareness Day in April 2014. Various relevant policies and mechanisms to support people with autism spectrum disorders and their families were being developed and implemented, and training programmes for nurses and community health workers had recently been updated to facilitate the early detection of autism spectrum disorders and the provision of timely and appropriate care at the primary care level.

Mr ZHANG Yong (China) said that the epidemiological and burden analyses in the report were objective and informative, and the priorities defined for national action to manage autism spectrum disorders were comprehensive and well-targeted. The key to managing such disorders was to ensure that patients had access to effective services. Governments and partners therefore needed to ensure coordination and cooperation at the national level, while the Secretariat should play a leading role in helping to improve multisectoral social support for the management of autism spectrum disorders. There should be a particular focus on developing countries and on training of personnel, capacity-building and the provision of adequate rehabilitation and behavioural treatment services.

Dr FEISUL IDZWAN MUSTAPHA (Malaysia) welcomed the Secretariat's work in drawing global attention to autism spectrum disorders. Global coordination on research on the etiology of autism spectrum disorders would help to resolve disputes regarding their causes and improve their biomedical management. He supported the draft resolution and the recommendations to provide comprehensive, integrated and responsive social and health care services, enhance access to services and ensure equal opportunities for people with autism spectrum disorders. To do so would require a whole-of-government approach and collaboration by governments with the private sector and nongovernmental organizations. Malaysia had integrated screening for autism spectrum disorders into child health services at the primary health care level; the opening of a centre of excellence to provide early intervention for children with such disorders and support for their families was planned for 2015.

Mr ALIMUZZAMAN (Bangladesh), speaking on behalf of the Member States of the South-East Asia Region, said that autism spectrum disorders, given their amplitude, complexity and contribution to disease burden, deserved specific attention. The high prevalence in many countries and the tremendous social and economic burden they entailed for both affected persons and their families were of great concern. The Mental Health Gap Action Programme had reviewed evidence on effective interventions for the management of developmental disorders, including autism spectrum disorders, and the news that it aimed to expand services for mental, neurological and substance-use disorders in resource-constrained settings was welcome. Persons with autism spectrum disorders should not be viewed as burdens on society; evidence showed that, with early intervention, they could contribute to society. He supported the draft resolution.

Ms IBRAHIM (Maldives) welcomed the recognition by WHO and other United Nations bodies of autism spectrum disorders as a global public health issue, a human rights issue and a development priority and urged the Secretariat to strengthen its efforts to support countries in translating that recognition into relevant national policies. Her Government had increased its efforts regarding autism spectrum disorders and other mental health disorders and welcomed the support provided through the Mental Health Gap Action Programme. It recognized the emotional and economic burden placed on the families of those with autism spectrum disorders, especially when access to services and support was inadequate. As Maldives lacked relevant professional capacity, it welcomed resolution SEA/RC65/R8 adopted by the Regional Committee for South-East Asia on the issue, which called on the Regional Director to collaborate with Member States and partners to strengthen national capacities to manage autism spectrum disorders.

Dr RIVERA (Bolivarian Republic of Venezuela) said that in 2013 his country's health ministry had recognized people with autism spectrum disorders as having life-long disabilities, which could affect them in varying ways during the life course in areas ranging from interpersonal relationships and self-care to education and employment. The report should have contained a statement to that effect. People with autism spectrum disorders were covered by a national programme, and indicators had been developed to measure the extent to which they were receiving comprehensive health care. Although the country's Constitution prohibited discrimination on the basis of disability, people with autism spectrum disorders continued to face obstacles to full participation as members of society and

lack of respect for their dignity and inherent value as people. The State intervened where necessary to uphold the right to non-discrimination.

Dr MWANSAMBO (Malawi), speaking on behalf of the Member States of the African Region, said that, in Africa and elsewhere, when it became apparent that a child had developmental problems, help might be sought first from traditional healers or religious leaders rather than health professionals, an action that could lead to late diagnosis. As a result, many children with autism spectrum disorders lacked language skills because they did not have early access to interventions such as speech therapy. Progress had been slow in the Region, but management of autism spectrum disorders was being incorporated into national mental health policies, strategies and service provision. Responses needed to be cross-cutting and based on universal access to and coverage of services as well as human rights and evidence. The burden of such disorders in Africa must be determined. Health care providers must be properly trained to identify and manage cases of autism spectrum disorders, and policy-makers should ensure that the necessary infrastructure was in place. He supported the draft resolution.

Dr MAHIPALA (Sri Lanka), expressing strong support for the draft resolution, said that autism spectrum disorders represented a major global challenge. Comprehensive care could significantly improve the lives of children with autism spectrum disorders, and strong and coordinated action was needed at the regional and global levels to improve access to such care. Access to both care and support was currently inadequate. A lack of budgetary provision in many countries had led to a heavy dependence on donor funding. Autism spectrum disorders needed to be high on public health agendas. The Secretariat should provide technical guidance on the formulation of policies, support access to training, raise public awareness and encourage research.

Mr SONG Young-jo (Republic of Korea) said that in his country the prevalence of autism spectrum disorders had increased four times faster than that of disability overall over the past five years. In 2012, nine Government ministries had collaborated to establish comprehensive measures relating to human rights, health care, education, child care and income security for those affected by autism spectrum disorders. Legislation had also been enacted to expand research on such disorders, improve access to the legal system and designate a specialist hospital for people with those disorders. He requested the Secretariat to articulate arguments as to why autism issues merited specific legislative measures, separate from other disability issues; to facilitate cooperation to promote early detection of autism spectrum disorders and to identify their causes and develop prevention and treatment programmes; to improve awareness of such disorders globally; and to facilitate enhanced care for affected persons and their families.

Dr SUNDARANEEDI (Trinidad and Tobago) noted that both WHO's and PAHO's action plans for prevention and control of noncommunicable diseases identified autism spectrum disorders as such conditions. They were a major public health concern worldwide and all countries must ensure high-quality public services that met the needs of persons with those and other developmental disorders. He supported the draft resolution's visions of easy access for people with autism spectrum disorders to efficient and multidisciplinary support services.

In line with the draft resolution, his Government planned to develop multidisciplinary diagnostic clinics and child assessment centres within existing health care facilities and would continue to collaborate with all stakeholders to improve areas where currently there were deficiencies, particularly in the provision of services such as speech and occupational therapy. It also aimed to develop a national disability registry.

Ms SALAZAR-GONZÁLEZ (Costa Rica), expressing support for the draft resolution, underlined the need to implement primary health care policies that focused on disease prevention and health promotion and that emphasized community outreach and social participation. Costa Rica had instituted a national policy on mental health that aimed to change the focus of care from hospitals to

the community, with services provided by specialists. For the implementation of that policy, Costa Rica needed continued support from headquarters and the Regional Office for the Americas.

Professor BAGGOLEY (Australia) supported the draft resolution. Autism spectrum disorders were a significant issue requiring appropriate intervention and support, which would call for expanding services in many countries. It was essential to continue to counter the pernicious and incorrect view that autism spectrum disorders could be caused by vaccination. The persistence of that view adversely affected both people with such disorders and those children whose parents mistakenly believed it was safest not to immunize them.

Ms KOROTKOVA (Russian Federation) said that the report accurately reflected the steps that needed to be taken in providing care for persons with autism spectrum disorders. Symptoms generally emerged at an early age but had an effect throughout the life course; for that reason, in her country attention focused on early detection, support to families and ensuring, through a multisectoral approach, the availability of appropriate medical, educational and other support services. The Russian Federation supported the draft resolution and looked forward to collaborating with the Secretariat in expanding the evidence base on autism spectrum disorders.

Dr BENJAMAS PRUKKANONE (Thailand) welcomed the draft resolution, the adoption of which would be a significant step in tackling developmental disorders and in striking the right balance between prevention, health promotion, treatment and rehabilitation. However, the global community needed to encourage greater political commitment to the effective management of autism spectrum disorders and other developmental disorders, including mobilization of resources to strengthen national policies and programmes. Further, the capacity of health systems had to be enhanced, particularly the availability and competency of mental health workers, so that autism spectrum disorders could be detected early and the appropriate treatment offered. Early intervention needed to be integrated into primary and secondary health care systems and links to specialized care services strengthened. In addition, social attitudes towards persons with autism spectrum disorders must be changed; it was not acceptable for society to exclude, discriminate against or stigmatize people with such disorders.

Mr JONES (Canada) said that his country was developing a national surveillance system that would provide the information and evidence needed to design effective interventions for autism spectrum disorders. It was also investing in community support and vocational training to improve the lives of persons with such disorders. As a sponsor of the draft resolution, he accepted the amendments proposed by the United States of America.

Dr VALVERDE (Panama) said that Panama had implemented a series of responses to autism spectrum disorders based on the cross-cutting principles of universal access to and coverage by services. A centre had recently been opened to provide education and comprehensive care to people with autism spectrum disorders and other cognitive disabilities and support to them and their families. The centre applied evidence-based practices and aimed to teach students the skills and knowledge necessary to everyday life and enable them to become independent and productive members of society. She supported the draft resolution and asked for Panama to be added to the list of sponsors.

Ms DOAN PHUONG THAO (Viet Nam), expressing support for the draft resolution, said that, although the ability of health care workers to identify autism spectrum disorders had improved and the stigmatization associated with such disorders had decreased, the prevalence of autism spectrum disorders was increasing and the capacity of her country and others to meet the needs of those affected remained limited. Her Government was developing a national mental health strategy, with the management of autism spectrum disorders an important component, but it continued to look to WHO for guidance on best practices. The Secretariat should make available standardized guidelines on screening, diagnosis and treatment of autism spectrum disorders, which would be useful to Member States, especially those with limited resources, in developing and mobilizing resources for country-specific action plans.

Dr PRIHARUM MARLINA (Indonesia) said that Indonesia's limited data on autism spectrum disorders indicated that the prevalence was increasing and that such disorders would become a major health problem. Indonesia had taken various steps in recent years to uphold the rights of children with special needs, including autism spectrum disorders. A national strategy had been formulated and a national action plan was being developed. Efforts were being made to increase understanding of autism spectrum disorders and enhance the ability of health workers at primary health care centres to provide the necessary services, including referral services to appropriate public or private hospitals; the services were covered by the national health insurance scheme. Challenges remained, however, with regard to coordination of services, regulation, community awareness and education of families. She supported the draft resolution and called on all stakeholders to build and maintain enabling environments for people with autism spectrum disorders.

Ms CABRERA (Ecuador) said that the creation of a national model for integrated care of people with autism spectrum disorders was one of the goals of her country's efforts to develop inclusive programmes and policies. Research would play a key role in the development of protocols for the early detection of such disorders. Public policies should encourage multisectoral action in order to facilitate early detection using standardized criteria. Treatment and rehabilitation services also needed to be strengthened at local and national levels, with special emphasis on services for children. Families played a crucial role in early detection, and national plans and policies should therefore be formulated in collaboration with civil society groups. She supported the draft resolution.

Dr LAHLOU (Morocco) said that his country attached special importance to autism spectrum disorders and welcomed its discussion by the Health Assembly. His Government was taking concrete measures to generate data on autism spectrum disorders, despite the difficulty of obtaining accurate scientific data on their causes. Civil society organizations played an important role in raising awareness and garnering support with a view to ensuring optimum health and social conditions for persons with such disorders. Numerous governmental sectors were also working to secure the financial and other resources needed to provide the best living conditions for those persons, support their families and assist them in integrating those with autism spectrum disorders into normal life. Expressing support for the draft resolution, he called on Member States to coordinate international action in order to assist countries in need of support and to adopt a participatory approach involving all those working in the area of autism, particularly nongovernmental and civil society organizations.

Dr PRASAD (India) said that India recognized the need to promote stronger coordinated action for managing autism spectrum disorders and other developmental disorders and recalled the recent creation of the South Asian Autism Network, which aimed to identify common challenges and foster partnerships in the South-East Asia Region. India had undertaken various activities in recent years, including the launching of a national child protection programme that promoted the early identification of birth defects, disabilities and developmental disorders and facilitated the necessary care, support and treatment for those conditions. A national trust on the welfare of persons with autism and other developmental disorders provided a forum for the dissemination of technical information on

those conditions. India endorsed the draft resolution and remained committed to developing policies, legislation and multisectoral plans on the management of autism spectrum disorders. However, it would require support from WHO and other partners for determining the burden of those disorders, designing and implementing early detection and surveillance systems, and implementing and evaluating cost-effective programmes.

Ms Hsiang-Yi HSU (Chinese Taipei) said that for more than 30 years Chinese Taipei had had an early intervention programme for autism spectrum disorders, based on multisectoral collaboration and cooperation in order to provide comprehensive health and welfare services. Several successful initiatives had been developed over the years, for instance in the areas of diagnosis, treatment and child psychiatry services; specialized centres existed and services were covered by health insurance. Screening of all two-year-olds was being introduced in order to facilitate early diagnosis and intervention. Further epidemiological data were needed, however, in order to plan more comprehensive and coordinated care. Chinese Taipei was committed to strengthening and updating policies and programmes for people with autism spectrum disorders.

Dr SAXENA (Mental Health and Substance Abuse) said that the Secretariat had noted the various suggestions made regarding the implementation of the draft resolution and would endeavour to provide the technical support needed to increase countries' capacity to tackle the burden of autism spectrum disorders. As suggested by various Member States, that work would be fully harmonized with the implementation of the comprehensive mental health action plan 2013–2020 adopted by the Sixty-sixth World Health Assembly and relevant regional resolutions and strategies, which were also grounded in the principles of universal health coverage and respect for human rights.

Dr DOLEA (Assistant Secretary), in response to a request by the CHAIRMAN, read out the amendments proposed by the delegate of the United States of America. In the sixth preambular paragraph, the word "lifelong" should be deleted; after the words "developmental disorders" the phrase "and conditions that emerge in early childhood and, in most cases, persist throughout the lifespan" should be inserted; the words "markedly abnormal or" and, in the next line, "significantly" should be deleted; after the word "interest" the phrase " , with or without accompanying intellectual and language disabilities" should be inserted; and the phrase "depending on the developmental level and chronological age of the individual" should be replaced by "in terms of combinations and levels of severity of symptoms". In the eighth preambular paragraph, the phrase "about the rising number of identified individuals with autism spectrum disorders and other developmental disorders," should be deleted, so that the text would begin: "Deeply concerned that individuals with autism spectrum disorders and ...". In subparagraph 1(1), the word "special" should be replaced by "specific".

The draft resolution, as amended, was approved.¹

The meeting rose at 12:35.

¹ Transmitted to the Health Assembly in the Committee's fifth report and adopted as resolution WHA67.8.

NINTH MEETING

Friday, 23 May 2014, at 14:40

Chairman: Dr P. RENDI-WAGNER (Austria)

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

Psoriasis: Item 13.5 of the Agenda (Documents A67/18, A67/18 Add.1 and EB133/2013/REC/1, resolution EB133.R2)

Dr PATTARAWALAI TALUNGCHIT (Thailand), supporting the draft resolution, said that psoriasis was not only a disease in an individual, but also reflected faults in health systems, such as poor health literacy and access to health care, low awareness and insufficient skills in the health workforce. The training of health professionals, particularly in primary and secondary care systems, was vital. The effectiveness of current programmes could be boosted through the use of networks of experts, communities of practice, collaboration with civil society groups, including self-help groups, and psoriasis centres around the world, which, if used strategically, could enhance the expertise of the trained workforce and raise awareness. Her country supported strengthening national programmes on psoriasis within health systems and endorsed World Psoriasis Day as a way of raising social awareness.

Dr SHAHANIZAN MOHD ZIN (Malaysia) urged that priority be given to further research on psoriasis to improve understanding of the disease process and develop more effective treatment. Research should also be conducted on complementary and alternative therapies, particularly their effectiveness, drug interaction and safety. She supported the draft resolution.

Dr ALLAH-KOUADIO (Côte d'Ivoire) observed that general practitioners sometimes had difficulty diagnosing cases of psoriasis, with the result that patients resorted to traditional medicine or managed their dermatosis alone. To deal with psoriasis, Côte d'Ivoire would need to make specific treatment available through the public health system; establish a forum for collaboration with psychologists, psychiatrists and traditional healers; provide multisectoral care; and collect additional data on the disease. In supporting adoption of the draft resolution, he called on partners to provide technical and financial support to help Côte d'Ivoire to combat the disease.

Mr ZHANG Yong (China) particularly welcomed the inclusion in the report of the call for further research, and appreciated the recommended actions. WHO should increase its support for etiological studies, and research into and development of new treatments for psoriasis.

Dr NIKEN WASTU PALUPI (Indonesia) observed that psoriasis lowered the quality of life because it primarily struck people of economically productive age. Her Government planned to improve access to services and essential medicines and to provide training and education for health care providers. It was also encouraging cooperation among parties concerned, including health professionals, family members and nongovernmental organizations, in order to eliminate stigmatization and raise awareness. Supporting the draft resolution, she requested WHO to provide technical support for her country's efforts.

Dr GALVEZ (Panama), recalling that WHO had not previously issued a report on psoriasis, said that the disease did not appear to be a priority. Nevertheless it should be dealt with as a major public health issue within the framework of noncommunicable diseases. Although psoriasis was equally prevalent in both sexes, there was a gender issue in that women encountered considerable difficulties in their treatment when pregnant or caring for babies. WHO should pay close attention to the disease, particularly in terms of recognition, prevention, awareness-raising and education.

Without wishing to reopen discussions on the text of the draft resolution, he proposed on behalf of the 26 sponsors amending the title to “Psoriasis”, as it had been listed thus in the agenda. He noted that the draft resolution would not incur significant costs for the Secretariat.

Mr ESCOBEDO (Guatemala) asked for Guatemala to be listed as a sponsor of the draft resolution.

Ms GIMÉNEZ LEÓN (Paraguay), supporting the draft resolution, emphasized the need to improve services for persons with psoriasis and the importance of educating health professionals about the symptoms of the illness and available treatments.

Dr KOBELA MBOLO (Cameroon), speaking on behalf of the Member States of the African Region, said that the main problems in the Region for tackling psoriasis were: insufficient data; incorrect or delayed diagnosis by health professionals; inadequate treatment options; poor access to care; stigmatization and discrimination; and in improving the quality of life of patients. As with other noncommunicable diseases, a strong programmatic and multidisciplinary approach to disease management was crucial, with coordination of care between specialists and other health care professionals, consideration of patients’ needs and preferences, and integration of management into existing services for noncommunicable diseases at all levels of care. It would be vital to ensure the commitment of policy-makers, improve access to services and essential medicines, and provide education and training to health care providers, particularly in primary care settings.

Dr AL-TAAE (Iraq) expressed support for the draft resolution, placing particular emphasis on the integration of preventive and curative services in primary health care services, delivery of evidence-based practices at the community level, advocacy, early detection and treatment, coordination between all levels of the health system and community participation, education in schools and more studies and operational research.

Mr JONES (Canada) said that a global report on psoriasis, as proposed in the draft resolution, would draw attention to the public health impact of psoriasis and provide valuable information and data on global incidence and prevalence. Canada welcomed WHO’s engagement on the issue and supported the draft resolution.

Ms CABRERA (Ecuador) recalled that Ecuador had been one of the drivers to include psoriasis on the agenda of the governing bodies and was a sponsor of the draft resolution. The report and the draft resolution were a step forward in drawing international attention to a condition that affected 125 million people. She expressed the hope that psoriasis would be allocated resources in the Organization’s programme budget. Implementing the provisions of the resolution would be one way to combat discrimination, improve patients’ quality of life and allow them to enjoy their full rights.

Mr AL-YAFII (Qatar) recognized the concern about the chronic nature of the disease, its complications, the lack of a cure, and the stigmatization and discrimination experienced by afflicted individuals in social and work settings. Raising awareness of psoriasis was essential together with more research into the causes of the disease and development of new treatments. Qatar provided facilities for diagnosis and treatment of psoriasis patients and observed World Psoriasis Day, which in 2013 had been marked with numerous meetings designed to increase awareness and offer advice to

afflicted persons. A free information leaflet had been produced in Arabic and English, as well as a guide to care and treatment. He recommended adoption of the draft resolution.

Ms GOMES (Brazil) said that, as for other noncommunicable diseases, implementing multisectoral programmes and strengthening primary health care were essential factors in ensuring early detection and successful treatment of psoriasis. She recalled that the draft resolution called on the Secretariat to draw attention to the public health impact, share best practices for integrating management of psoriasis into existing services, and to publish a global report on psoriasis. She supported the draft resolution and emphasized the importance of observing World Psoriasis Day.

Mr PABLOS-MENDEZ (United States of America) shared the concern that psoriasis was not well recognized, especially given the risk for serious complications for psoriasis patients, including mental health conditions and socioeconomic problems arising out of stigmatization and discrimination. A necessary step in tackling psoriasis worldwide was to raise awareness. He thanked the governments, including that of Panama, which had championed the cause in the Executive Board.

Ms GAILIUTE (Lithuania) supported the draft resolution.

Dr KISAKA (Japan), recognizing the importance of tackling psoriasis, requested clarification on WHO's future approaches, not only to psoriasis, but to other rare or intractable diseases with no established cause or treatment. Her country was currently revising measures for handling all intractable diseases, and considered it appropriate to tackle psoriasis through comprehensive measures applicable to all intractable diseases. Guidelines for managing psoriasis were being drawn up. The decision to observe World Psoriasis Day, and related activities, should be at the discretion of each country.

Ms DOAN PHUONG THAO (Viet Nam), supporting adoption of the draft resolution, affirmed her Government's commitment to improving the health system's capacity to prevent and control noncommunicable diseases, including psoriasis. She asked the Secretariat to consider developing comprehensive clinical guidelines for dealing with psoriasis at the primary health care level and to emphasize in guidelines for other common noncommunicable diseases that psoriasis patients were at a higher risk of contracting those diseases. She thanked WHO for its support in updating Viet Nam's national strategy on noncommunicable diseases and requested ongoing support in that area.

Mr MERCADO (Argentina) supported the calls for adoption of the draft resolution. He thanked the other sponsors, and recognized Panama's leadership in the matter.

Dr SUNDARANEEDI (Trinidad and Tobago) expressed support for the draft resolution and its encouragement of raising awareness about the disease and fighting stigmatization. The draft resolution's provisions should be incorporated into each Member State's policy on noncommunicable diseases. In Trinidad and Tobago, patients with dermatological conditions were managed through a primary health care approach, with referral as necessary to tertiary centres. Although incremental exposure to natural light could serve as an additional treatment regimen in sunny climates, the country had no phototherapy units available. He requested WHO's support to establish such centres.

Mr LEGGE (Medicus Mundi International – International Organisation for Cooperation in Health Care), speaking at the invitation of the CHAIRMAN, said that some medications for psoriasis were among the highest revenue-earning medicines in the world. As they were vital to companies' profits, it was reasonable to speculate that one motive for pharmaceutical companies' support for World Psoriasis Day was to expand the global market for their products. In the discussion of the draft resolution by the Board at its 133rd session, no possible conflict of interest was mentioned by its sponsors, the Secretariat or the International Alliance of Patients' Organizations, whose members

included psoriasis associations supported by pharmaceutical companies.¹ He urged the Health Assembly not to endorse World Psoriasis Day.

Ms GALLANT (International Alliance of Patients' Organizations), speaking at the invitation of the CHAIRMAN, said that the physical, psychosocial and socioeconomic burden of psoriasis was significant. Psoriasis should be diagnosed and managed early; patients and health professionals should be made aware of the disease and the risk of comorbidities; and the public should be educated that it was not contagious. She encouraged Member States to give due consideration to the key actions listed in the report and help to raise awareness and understanding. She urged delegates to adopt the draft resolution.

Dr MENDIS (Chronic Diseases Prevention and Management) confirmed that WHO would help to draw attention to the public health impact of psoriasis and reduce discrimination and stigmatization of people affected by the disease. WHO would also promote the need for further research into psoriasis and provide technical support for identifying affordable ways to integrate psoriasis into existing noncommunicable diseases services, particularly in primary health care through affordable approaches. In response to a question by the delegate of Japan, the approaches identified for psoriasis could also be used for other intractable noncommunicable diseases.

At the request of the CHAIRMAN, Dr ARMSTRONG (Secretary) recapitulated the proposed amendment: Panama had proposed deleting the words "World" and "day" from the title of the draft resolution, which would simply read "Psoriasis".

The CHAIRMAN said that, in the absence of any objection, she took it that the Committee wished to approve the draft resolution, as amended.

The draft resolution, as amended, was approved.²

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

Newborn health: draft action plan: Item 14.2 of the Agenda (Documents A67/21 and A67/21 Corr.1)

The CHAIRMAN drew attention to a draft resolution proposed by the delegations of Cameroon, Canada and Malawi. The text read:

The Sixty-seventh World Health Assembly,

PP1 Having considered the reports on the newborn health: draft action plan,³ monitoring the achievement of the health-related Millennium Development Goals⁴ and health in the post-2015 development agenda;⁵

¹ See summary records of the fourth meeting, section 1, of the Executive Board at its 133rd session (document EB133/2013/REC/1).

² Transmitted to the Health Assembly in the Committee's fifth report and adopted as resolution WHA67.9.

³ Document A67/21.

⁴ Document A67/19.

⁵ Document A67/20.

PP2 Recalling resolution WHA58.31 on working towards universal coverage of maternal, newborn and child health intervention, resolution WHA63.15 on monitoring of the achievement of the health-related Millennium Development Goals, resolution WHA64.9 on sustainable health financing structures and universal coverage, resolution WHA64.13 on working towards the reduction of perinatal and neonatal mortality, and resolution WHA65.7 on implementation of the recommendations of the Commission on Information and Accountability for Women's and Children's Health;

PP3 Acknowledging the pledges and commitments made by a large number of Member States and partners to the United Nations Secretary-General's Global Strategy for Women's and Children's Health, which aims to save 16 million lives by 2015;

PP4 Recognizing that millions of children and women die needlessly each year during and around the time of childbirth, and that effective interventions are available and feasible for implementation at scale to end preventable maternal, newborn and child deaths;

PP5 Concerned that there has been insufficient and uneven progress towards achieving Millennium Development Goal 5 (Improve maternal health) and that, although progress has been made towards achieving Millennium Development Goal 4 (Reduce child mortality) in terms of the overall reduction of child mortality, the reduction of perinatal and neonatal mortality has stagnated and the proportion of neonatal deaths among all child deaths is increasing;

PP6 Recognizing the need to intensify action urgently in order to end preventable neonatal deaths and preventable stillbirths, especially by improving access to and quality of health care for women and newborns, including the prevention of the transmission of HIV from mother to child, within the continuum of care for reproductive, maternal, newborn and child health,

1. ENDORSES the newborn health: action plan,¹
2. URGES Member States to put into practice the newborn health: action plan, through steps that include:
 - (1) reviewing, revising and strengthening their national strategies, policies, plans and guidelines for reproductive, maternal, newborn and child health in line with the goal, targets and indicators defined in the newborn health: action plan;
 - (2) committing themselves to allocating adequate human and financial resources to improve the quality of care and achieve the national newborn health targets in line with the global action plan;
 - (3) strengthening national health management information systems so as better to monitor quality of care and to track progress towards ending preventable maternal and neonatal deaths and stillbirths;
 - (4) reporting every second year to the Health Assembly on lessons learnt, progress made, remaining challenges and updated actions to reach the national newborn and maternal health targets;
3. REQUESTS the Director-General:
 - (1) to foster alignment and coordination of all stakeholders in order to mobilize more financial resources and support the implementation of the newborn health: action plan;
 - (2) to identify human and financial resources for the provision of technical support to Member States in implementing the newborn health component of national plans and monitoring their impact;

¹ Contained in document A67/21.

(3) to monitor progress and report every second year, until 2030, to the Health Assembly on progress towards achievement of the global goal and targets using the proposed monitoring framework to guide discussions and future actions.

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

<p>1. Resolution: Newborn health: draft action plan</p>		
<p>2. Linkage to the Programme budget 2014–2015 (see document A66/7 http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_7-en.pdf)</p> <p>Category: 3. Promoting health through the life course</p> <table> <tr> <td>Programme area(s): Reproductive, maternal, newborn, child and adolescent health</td> <td>Outcome: 3.1 Output: 3.1.1</td> </tr> </table> <p>How would this resolution contribute to the achievement of the outcome(s) of the above programme area(s)?</p> <p>The resolution would contribute to the achievement of the outcomes in the programme area mentioned above by supporting the human and financial resources required (i) for the provision of technical support to Member States in implementing the newborn health component of national plans; (ii) for monitoring their implementation, impact and progress; and (iii) for preparing report to the Health Assembly every second year.</p> <p>Does the programme budget already include the outputs and deliverables requested in this resolution? (Yes/no)</p> <p>Yes.</p>	Programme area(s): Reproductive, maternal, newborn, child and adolescent health	Outcome: 3.1 Output: 3.1.1
Programme area(s): Reproductive, maternal, newborn, child and adolescent health	Outcome: 3.1 Output: 3.1.1	
<p>3. Estimated cost and staffing implications in relation to the Programme budget</p> <p>(a) Total cost</p> <p>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).</p> <p>(i) Four years (covering the period 2014–2017)</p> <p>(ii) Total: US\$ 34.40 million (staff: US\$ 10.45 million; activities: US\$ 23.95 million)</p> <p>(b) Cost for the biennium 2014–2015</p> <p>Indicate how much of the cost indicated in 3(a) is for the biennium 2014–2015 (estimated to the nearest US\$ 10 000).</p> <p>Total: US\$ 18.93 million (staff: US\$ 5.21 million; activities: US\$ 13.72 million)</p> <p>Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant.</p> <p>Implementation would take place at all levels of the Organization and across all regions.</p> <p>Is the estimated cost fully included within the approved Programme budget 2014–2015? (Yes/no)</p> <p>Yes.</p> <p>If “no”, indicate how much is not included.</p>		

(c) Staffing implications**Could the resolution be implemented by existing staff? (Yes/no)**

Yes, but funding for current staff needs to be assured.

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 2014–2015 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\$ 9.47 million. This funding gap will be tackled through the Organization-wide coordinated resource mobilization plan to deal with funding shortfalls in the Programme budget 2014–2015.

Dr BAYE LUKONG (Cameroon) proposed that directly after the fourth preambular paragraph of the draft resolution, a new paragraph be added, the fifth preambular paragraph be divided into two, and in the sixth preambular paragraph, the words “particularly of those at risk” be added after “newborns”, so that the new formulation would read:

PP5 Recognizing that ending preventable maternal mortality is within reach and that its achievement will accelerate the achievement of the newborn mortality target;

PP6 Concerned that there has been insufficient and uneven progress towards achieving Millennium Development Goal 5 (Improve maternal health);

PP7 Also concerned that, although progress has been made towards achieving Millennium Development Goal 4 (Reduce child mortality) in terms of the overall reduction of child mortality, the reduction of perinatal and neonatal mortality has stagnated and the proportion of neonatal deaths among all child deaths is increasing;

PP8 Recognizing the need to intensify action urgently in order to end preventable neonatal deaths and preventable stillbirths, especially by improving access to and quality of health care for women and newborns, particularly of those at risk, and including the prevention of the transmission of HIV from mother to child, within the continuum of care for reproductive, maternal, newborn and child health.

Further, at the end of subparagraph 2(1), “and strongly committing to their implementation” should be added; subparagraph 2(2) should be redrafted to read “committing themselves to allocating adequate human and financial resources to improve the access to and quality of care, particularly but not limited to care for the mother and the child during labour, around birth and the first week, and achieve the national newborn health targets in line with the global action plan”; in subparagraph 3(1), the words “in order to mobilize more financial resources and” should be deleted; and in subparagraph 3(2), the words “and mobilize, within approved current and subsequent, programme budgets, more” should be added after the word “identify”.

Dr ALHAMAD (Kuwait) proposed that “early initiation of breastfeeding” should be included as a core indicator in Annex 2 to document A67/21. In the second preambular paragraph of the draft resolution, the following wording should be inserted after the word “Recalling”: “resolution WHA55.25, which endorsed the global strategy for infant and young child feeding to improve early and exclusive breastfeeding rates and complementary feeding”. In the sixth preambular paragraph of the same draft resolution, the phrase “by improving access to and quality of health care for women and

newborns”, should be replaced with “by improving early and exclusive breastfeeding and access to and quality of health care during pregnancy, childbirth and breastfeeding for women and newborns”.

Ms KAK (United States of America), announcing her country’s wish to cosponsor the draft resolution as amended by Cameroon, noted with satisfaction the inclusion in the draft action plan of an integrated maternal and newborn health approach. Development partners, civil society and the private sector in all countries should align their actions with the objectives of the plan. The action plan would be strengthened by containing both newborn and maternal mortality targets. In addition, in the second sentence of paragraph 15 of the plan, she proposed adding “and, recognizing that ending preventable mortality is within reach and that its achievement will accelerate the achievement of the newborn mortality target, at a recent UN-led conference in Bangkok international partners agreed upon a global average maternal mortality ratio target of less than 70 maternal deaths per 100 000 live births by 2030”. She encouraged WHO, in the context of the draft action plan, to work with partners and leverage existing efforts to contribute to reaching both newborn and maternal mortality targets.

Dr CHAND (Nepal), speaking on behalf of the Member States of the South-East Asia Region, welcomed the efforts by WHO and UNICEF to draft the action plan. Despite significant improvements in reducing infant and child mortality in recent decades, neonatal mortality remained high in South-East Asia, accounting for more than 50% of under-five mortality in some countries. Many causes of newborn deaths were preventable and could be resolved through low-cost and innovative interventions, rather than traditional approaches. Commitment should be renewed to enhancing the effective implementation of interventions covering the continuum of care from pre-pregnancy to the postnatal period, with particular focus on quality of care around the time of birth, in order to prevent both neonatal and maternal deaths. Effective implementation of the plan would require increased efforts in each country to secure political commitment, as some interventions in the plan required special attention to extend, such as the use of antenatal corticosteroids for suspected premature births. To implement the plan effectively, the health system at large would need to be strengthened, in particular by recruiting and training skilled birth attendants, improving health information and focusing on vulnerable and high-risk groups. The plan would give the impetus to enhance the Region’s governance framework and strategies and, although the target of less than 10 neonatal deaths per 1000 live births by 2035 was ambitious, it should be embraced by all Member States committed to ending preventable newborn deaths.

Dr PATTARAWALAI TALUNGCHIT (Thailand) pointed out that the draft action plan provided guidance regardless of the context of newborn health in each country. Thailand, for example, had already achieved the maternal and neonatal mortality goals and sought advice on how to proceed further. Integrating mortality targets with quality-oriented and equity-oriented targets might also be advisable. The plan should also target high-risk groups, including teenagers and migrants, who generally had lower access to health and social care of good quality. Social determinants of health had received scant mention in the plan, but should be taken into account in its implementation as, like universal health coverage, core cross-cutting concepts at both national and international levels.

She proposed four amendments to the draft resolution: in the sixth preambular paragraph, the words “especially for high-risk groups” should be inserted after “women and newborns,”; after the last sentence of subparagraph 2(1), the words “with particular focus on high-risk groups” should be added; in subparagraph 2(2), the words “improve the quality of care” should be replaced with “improve the access to and quality of care”; and the start of subparagraph 2(3) should read “strengthening health information systems”, instead of “strengthening national health management information systems”.

The CHAIRMAN suspended the discussion of the agenda item in order to discuss agenda item 16.4 on poliomyelitis: intensification of the global eradication initiative.

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

3. PREPAREDNESS, SURVEILLANCE AND RESPONSE: Item 16 of the Agenda

Poliomyelitis: intensification of the global eradication initiative: Item 16.4 of the Agenda (Document A67/38)

Ms FAROOQ (Pakistan) said that her country was fully committed to polio eradication and aware of its responsibilities as a member of the international community. The persistence of poliovirus in Pakistan was primarily due to the unparalleled challenges of insecurity. Polio eradication had been declared a national health emergency and all relevant institutional mechanisms were fully geared to combating the disease. All provinces had been advised to implement the recommendations of the International Health Regulations (2005), and vaccination counters had been set up at all international ports as well as at some district hospitals. The Prime Minister was leading the polio eradication initiative, with the chief of the army and all relevant agencies responsible for providing security for vaccination teams in all compromised areas. Moreover, extensive polio immunization activities had been conducted up until May 2014, consisting of three nation-wide, two subnational and four targeted vaccination rounds. To protect poliomyelitis-free areas from reintroduction of the virus through population movement, permanent transit vaccination points had been set up at district, provincial and international borders. In the first quarter of 2014, 3.4 million children had been vaccinated and vaccination refusals were at their lowest level thanks to an effective advocacy strategy. The Government had registered and approved the introduction of the inactivated poliovirus vaccine in selected high-risk areas for 2014, and routine immunization would begin in 2015. Nevertheless, the requirements of the International Health Regulations (2005) were a burden on vaccine reserves already overstretched by the supplementary immunization programmes. Furthermore, 90% of the cost of the vaccination programme was borne by the Government and additional vaccine procurement would drain resources. Pakistan, determined to eradicate polio, requested support and understanding from the international community.

Professor BAGGOLEY (Australia) supported the objectives of the Polio Eradication and Endgame Strategic Plan 2013–2018 and welcomed efforts to strengthen vaccination activities, especially in countries where the disease was endemic or active conflict affected the delivery of routine vaccine programmes. Authorities should commit themselves to ensuring unhindered and safe access for vaccination service providers, as the worrying insecurity and attacks on health workers threatened children's right to health and jeopardized the progress towards eradication made so far.

Ms LANTERI (Monaco), speaking on behalf of the Member States of the European Region, warned that an inadequate global response could result in failure to eradicate polio. Containment and certification, strengthening routine immunization programmes and introducing inactivated poliovirus vaccine needed to be promoted at national and international levels. The South-East Asia Region's outstanding achievement of being certified polio-free proved that a shared commitment could make the goal of ending poliomyelitis a reality. New cases in Pakistan, the Middle East and Africa, however, threatened to reverse decades of progress and efforts needed to be stepped up immediately in order to reach the goal. She fully supported the Director-General's decision to apply the recommendations of the Emergency Committee of the International Health Regulations (2005) and she called on all Parties to implement them.

The European Region was fully committed to cooperating with neighbouring regions. As surveillance of acute flaccid paralysis was the backbone of detecting poliovirus and its high quality must be maintained, she called on WHO to consider setting up evidence-based standards for environmental surveillance of poliovirus. Based on local risk assessment, Member States should consider using different methods of surveillance, such as monitoring waste waters for wild poliovirus. High vaccination coverage in all geographical areas and population groups would also protect countries from the spread of poliovirus, although priority should be given to affected countries, especially those exporting the virus. She asked what measures had been taken by the Organization in

that regard. As there was clearly a strong linkage between conflict and the spread of poliovirus, she called on all parties to ensure immunization coverage in secure conditions for both the population and health workers.

Dr AMMAR (Lebanon) said that his country, free of poliomyelitis for more than a decade, currently risked a resurgence because of outbreaks in neighbouring countries and the constant circulation of poliovirus in the Middle East. Lebanon faced the brunt of recent population displacements as a consequence of the armed conflict in the Syrian Arab Republic, but supported vaccination of the displaced population currently living in the country and was actively participating in the multi-country outbreak response involving the vaccination of 22 million children across the region. Surveillance with the aim of rapid detection of poliovirus had been upgraded and a series of nationwide poliomyelitis vaccination campaigns had been undertaken. He called on the international community to support regional efforts to control the recent outbreaks and work towards the eradication of poliovirus from the region.

Dr ALABOUD (Syrian Arab Republic), expressing support for the Polio Eradication and Endgame Strategic Plan 2013–2018, said that his country had been poliomyelitis-free since 1995 and that immunization coverage had always exceeded 95%. Owing to geopolitical circumstances, however, the disease had unfortunately re-emerged and health workers had been subjected to attacks, but most children had been vaccinated thanks to the volunteer efforts of health students during the course of seven immunization campaigns. The last case of poliomyelitis had occurred in early 2014 and four more immunization campaigns were in the offing. Emphasis must be placed on the importance of immunizing children with several doses of vaccine, support for surveillance of acute flaccid paralysis, continuing WHO support, particularly to countries in crisis, and coordination between neighbouring countries. WHO must play a greater role in ensuring implementation of the Strategic Plan by all stakeholders.

Ms GOLBERG (Canada) said that Canada was proud to be a long-term supporter of global efforts to eradicate poliomyelitis, acting for instance as co-chair of the Global Polio Partners Group. Collective commitment to eradicate the disease was strong and success was tantalizingly within reach. With the eradication of polio in India – one of the most significant public health success stories in recent years – the disease had been eradicated in 80% of the world. Over the previous year, great improvements had been made in coherence between routine immunization and the polio eradication effort, reflecting Member States' recognition that more integrated services needed to be offered if transmission of the virus was to be interrupted and the confidence of the community gained. The enhanced cooperation between the Global Polio Eradication Initiative and the GAVI Alliance was encouraging.

Nevertheless, success was fragile and three countries remained endemic for poliomyelitis; without success in those countries, there would be a perpetual cycle of re-emergence. Outbreaks in the Syrian Arab Republic, the Horn of Africa and West Africa showed the profound danger of children being needlessly paralysed and economies undercut. Good progress had been made in Nigeria, although Borno state still faced issues of security and campaign quality; Afghanistan had seen a marked decrease in poliovirus infection rates; but in Pakistan, the increase in confirmed cases and the lack of safety and security of vaccination teams were of deep concern. She urged the Government of Pakistan to continue to improve security arrangements for health workers and to pursue innovative approaches, including increasing access to high-risk communities.

Drawing attention to WHO's leadership in containing the Middle East outbreak, she said that Canada stood ready to provide further support. To achieve eradication, the reach of the immunization campaigns must be sustained and access to children in all besieged areas augmented and complemented with other health services, as the progress so far was delicate and reversible. A coordinated international response was required to limit the spread of poliovirus, and the recommendations of the Emergency Committee of the International Health Regulations (2005) should

contribute to that. Success, however, would depend on the effective introduction of the inactivated poliovirus vaccine. Results of a recent tender for the vaccine were encouraging and she looked to the leadership of the Global Polio Eradication Initiative and the GAVI Alliance to ensure that the vaccine was introduced.

Dr MASHAL (Afghanistan) said that his country was making good progress and was on track to reach its goal of polio eradication. There had been a 62% reduction in cases during the previous year and no case reported in the southern region for more than one year. Several key interventions and innovative approaches had been adopted in 2013, including 19 supplementary immunization activities in low-performing districts. Afghanistan was currently focusing efforts on the southern region and the Kunar province and had set out three priorities: access to children in difficult and insecure districts, improving campaign quality within accessible areas and replicating national-level political commitments at the provincial level. Afghanistan planned to introduce the inactivated poliovirus vaccine between 2014 and 2015 and carry out joint activities to vaccinate children crossing the border between Pakistan and Afghanistan.

Mr ELIAS (Ethiopia) said that indigenous wild poliovirus had last been detected in Ethiopia in December 2001, although the virus had been imported into the country on various occasions between 2004 and 2008 and in 2013 and 2014. Those cases had been successfully contained through high-quality supplemental immunization activities, improved routine immunization and enhanced surveillance, and no case had been reported since February 2014. The Government was committed to keeping Ethiopia polio-free and was working with partners to achieve that aim.

Mr ZHANG Yong (China) welcomed the progress made towards eradicating poliomyelitis, but recognized remaining major challenges. Regional attainment of targets was varied, and there had been a resurgence of cases in some countries and regions from imported wild poliovirus. It was essential to coordinate efforts to provide technical and financial support to affected countries and those most at risk and to facilitate the improvement of routine vaccine coverage rates. There was also a need for enhanced border surveillance activities and regular risk evaluation to prevent importation of poliomyelitis. Recommending the implementation of information- and data-sharing mechanisms with intercountry and interregional cooperation, he highlighted the importance of the timely delivery of the results of analysis of the effectiveness of poliomyelitis vaccination strategies, as well as the need to provide enhanced support to developing countries, taking into account national conditions. Additional guidance should be given to Member States regarding use and supply of the inactivated poliovirus vaccine. In that connection, his Government was adjusting its vaccination strategy in line with domestic circumstances and WHO's recommendations.

Ms RIOS (Argentina) underlined the value of the knowledge and experience gained in the Global Polio Eradication Initiative for other public health initiatives. It was essential to improve surveillance systems, increase coverage of immunization programmes, implement supplementary immunization activities and establish plans for the introduction of at least one dose of the inactivated poliovirus vaccine into routine immunization programmes by the end of 2015. The high demand for the inactivated poliovirus vaccine would, however, lead to a rise in cost and difficulties in ensuring the required supplies, with developing countries faring worst. Argentina was analysing the possibility of initiating domestic production of the inactivated poliovirus vaccine, in line with principles of timely and equitable access. She urged WHO to give consideration to the importance of universal access to vaccines, promoting production and availability.

Dr BROU (Côte d'Ivoire) said that no case of poliomyelitis due to wild poliovirus had been reported in his country since July 2011. It would continue to implement existing strategies, in particular: bringing surveillance activities up to the standards required for certification of eradication; expanding coverage of the national routine vaccination programme; and organizing and improving the

quality of supplementary immunization activities through, inter alia, independent monitoring and data analysis. Introduction of a single dose of injectable poliovirus vaccine as part of the routine immunization programme was scheduled for 2015.

Ms GOMES (Brazil) expressed concern that, although an increased number of children were being vaccinated in countries endemic for poliomyelitis, the number of cases in Africa and Asia was rising owing to difficulties in accessing priority areas, as evidenced by the recent WHO declaration of a public health emergency of international concern. Brazil offered its cooperation with Member States and the Secretariat in surveillance and vaccination activities. To work towards the goal of eradicating poliomyelitis by 2018, her Government strongly supported actions enabling poliomyelitis-affected countries to apply immediate emergency measures to remove remaining obstacles to providing oral poliovirus vaccine, implement containment activities for poliovirus by the end of 2015, strengthen surveillance and implement the recommended poliovirus vaccination of travellers.

Ms SINGH (South Africa) noted with concern the increase in the number of cases of poliomyelitis and supported the call for greater urgency in implementing strategies to eradicate the disease. South Africa remained poliomyelitis-free, as a result of which all stocks of cloned poliovirus had been destroyed in January 2014 under the supervision of WHO.

Professor LEVENTHAL (Israel) said that wild poliovirus had been detected in environmental samples collected in Israel in 2013. WHO had been immediately informed through the mechanism defined in the International Health Regulations (2005) and provided support in the form of two missions, whose recommendations had been fully implemented. Although Israel had been using exclusively inactivated poliovirus vaccine for several years, his Government had been obliged to reintroduce a policy of using both oral and inactivated poliovirus vaccines. No poliovirus had been detected in the environment in the previous two months. He thanked the Director-General and the Regional Director for Europe for their support.

Global standards for environmental surveillance of poliomyelitis must be established, as well as a mechanism to evaluate the results, whose effectiveness would depend on the capabilities of Member States' public health laboratories. WHO should develop a policy and criteria for situations where environmental poliovirus had been detected but without clinical cases. The current threat posed by the transmission of poliovirus could provide an opportunity for further progress and enhanced cooperation between Israel and its neighbours, for instance within the framework of the International Health Regulations (2005) and under the leadership of WHO. He expressed appreciation for the visit of the Director-General and the Regional Directors for Europe and the Eastern Mediterranean to Israel.

Dr AL-TAAE (Iraq) said that it would be practical to identify the challenges encountered by WHO in providing technical support to countries. The first related to monitoring access to type 2 oral polio vaccine, especially given its use in immunization campaigns. In Iraq, more than 5.5 million children and some 500 000 displaced Syrian children had been immunized in each of the six campaigns conducted alongside information campaigns following the emergence of two cases of poliomyelitis. The second lay in monitoring the introduction of inactivated poliovirus vaccine, currently in use in only 71 countries, with a further 85 countries preparing for its introduction and 39 with no plans to follow suit. As the resulting discrepancy could lead to epidemiological variations, relevant surveys and studies should be coordinated with WHO. Environmental monitoring and monitoring of acute flaccid paralysis were also important. WHO must also study and monitor the health risks of mass gatherings, especially in countries hosting religious pilgrimages, such as Iraq. Region-wide poliomyelitis awareness campaigns must be carried out, even in disease-free countries, on the basis of solidarity for health and for poliomyelitis eradication.

Dr AL RAND (United Arab Emirates), expressing appreciation for the intensified efforts to eradicate poliomyelitis, commended the newly launched stage of the Strategic Plan, as it aimed to halt

the spread of wild poliovirus by the end of 2014, promote routine immunization and set a target date for certification of poliomyelitis eradication. The national plan in his country focused on meeting standards for surveillance, reducing risk factors for re-emergence of the disease, optimizing vaccine use, monitoring for vaccine-derived poliovirus, and continuing high vaccination coverage rates in accordance with the national immunization plan. WHO's declaration of a public health emergency of international concern was timely, as it gave States a strong incentive for strengthening and expanding their programmes for poliomyelitis eradication and surveillance of acute flaccid paralysis.

Dr AL HAJERI (Bahrain) said that the inability to immunize children in conflict-affected countries gravely threatened global health. Efforts to protect vaccination campaign workers must be stepped up and surveillance and immunization activities strengthened in order to minimize the risk that poliovirus might spread. Bahrain had been poliomyelitis-free since 1994 owing to the high rates of coverage with the three routine doses of poliomyelitis vaccine (which had exceeded 99% since 2010), and national immunization campaigns. All documentation and activities relating to poliomyelitis eradication had been reviewed by a national certification committee. Eradication efforts must be intensified, particularly in conflict-affected countries.

Dr MOHAMMED (Nigeria) assured the Health Assembly of Nigeria's deep commitment to eradicating poliomyelitis. Significant progress had been made since the declaration of the disease as a national programmatic emergency: as of May 2014, only three reports of wild poliovirus type 1 had been received from two states, representing a 96% reduction compared to the same period in 2013, and the last reported isolation of wild poliovirus type 3 had been in November 2012. Southern Nigeria had been poliomyelitis-free for four years and efforts were being undertaken to maintain that status. In line with the priority accorded to his country's poliomyelitis eradication initiative campaigns, several measures had been taken, including restructuring poliomyelitis-related activities in security-compromised areas, outreach to underserved populations, improving routine immunization activities, implementing an accountability framework and placing immunization posts in the border areas of the parts of the country that were endemic for the disease. The proposed nationwide introduction of the inactivated poliovirus vaccine into routine immunization programmes in December 2014 had been advanced to June 2014 in insecure or underserved areas. Nigeria had begun implementation of the International Health Regulations (2005) by introducing a card to record all required international vaccinations. Mandatory oral polio vaccinations were being given to travellers from Nigeria to India and would be extended to travellers to other countries as necessary.

Mr KOLKER (United States of America), welcoming the informative and candid report, said that the significant reduction in the number of reported cases in Afghanistan and Nigeria was impressive, especially in the light of the insecurity in certain endemic areas, and saluted India's sustained poliomyelitis-free status. Circulation of the poliovirus in Nigeria could be interrupted by the end of 2014 with sustained high-level political commitment. His Government offered its sympathies to the families of health workers targeted in attacks. As international travel posed a key threat to the success of the Global Polio Eradication Initiative, he expressed gratification that vaccination programmes for travellers would soon be implemented by Pakistan and welcomed the reported high-level political commitment. It was imperative to tackle all outbreaks of the disease with urgency so as to prevent spread to neighbouring countries and beyond. His Government applauded the Director-General's decision to convene a meeting of the Emergency Committee under the International Health Regulations (2005) to discuss the issue of vaccinations for travellers and endorsed the convening of another meeting within the next three months. He urged Member States receiving large numbers of travellers from areas where the disease was endemic to conduct environmental surveillance in order to detect cases of infection and requested countries to provide updates on the status of implementation of the recommendations established within the framework of the International Health Regulations (2005).

Dr SUNDARENEEDI (Trinidad and Tobago) said that his country was committed to achieving global eradication of poliomyelitis through a range of national initiatives, in line with the objectives and recommendations of the Polio Eradication and Endgame Strategic Plan 2013–2018. Although the threat from vaccine-preventable diseases, including poliomyelitis, had diminished in Trinidad and Tobago as a result of the national vaccination programme, the need for sustainability remained to ensure the attainment of national goals. Endorsing the guiding principles of the global vaccine action plan, which would steer his country's progress towards maintaining immunization coverage of more than 95% by 2015, he expressed the hope that the goal of eliminating vaccine-preventable diseases would be reached by 2020.

Mrs TYSON (United Kingdom of Great Britain and Northern Ireland) said, as a representative of a country that was a major donor and long-term supporter of the Global Polio Eradication Initiative, that, in the face of a resurgence of the disease, efforts must be scaled up with full engagement from all stakeholders in order to avoid the risk of undermining the progress made over decades.

Mr HO (Singapore), expressing appreciation of the comprehensive report, was encouraged that milestones towards global eradication had been reached. Concerted efforts by multiple stakeholders had led to India being declared poliomyelitis-free in January 2014, with the result that the South-East Asia Region had been similarly certified in March 2014. However, the recent outbreaks of the disease in Asia, Africa and the Eastern Mediterranean Region were a matter of concern and would require a coordinated international response. He thanked WHO for its continued leadership and for according poliomyelitis the necessary priority at the global level, thereby ensuring awareness of the international public health emergency. Expressing his country's solidarity with the affected regions, he encouraged implementation of the emergency measures recommended by the Emergency Committee. Swift and decisive actions were needed to ensure that the progress made over nearly three decades to eradicate poliomyelitis was not lost.

Dr MANAMOLELA (Lesotho), recognizing the efforts to eradicate poliomyelitis in the African Region, said that the Polio Eradication and Endgame Strategic Plan 2013–2018 was being adapted to the regional context and incorporated into the regional immunization strategic plan 2014–2020. Regional advances had been made, particularly in the case of Nigeria. Although no case had been detected in Lesotho since 1988, the country continued to conduct acute flaccid paralysis surveillance and other preventive activities, providing annual updates to the African Regional Certification Commission. Health personnel had been trained in integrated disease surveillance and response in 2013. Lesotho was committed to finalizing before the end of 2014 a plan for introducing inactivated poliovirus vaccine, in line with the recommendations of the Strategic Advisory Group of Experts on immunization. She requested technical support from WHO and its partners to monitor and promote the introduction of the new vaccine and the implementation of actions to improve programme performance.

Ms CHO Soo-nam (Republic of Korea) said that the recent resurgence of poliomyelitis in parts of Africa and Asia had demonstrated the need for continued and intensified work and investment to eradicate the disease. It was important to coordinate global efforts and build on the achievements made thus far, especially the implementation of information-sharing and vaccination programmes in countries in which the disease was endemic. Her country continued to stress poliomyelitis vaccination programmes in accordance with WHO's response guidelines. Measures must be established to ensure the safety of health workers implementing vaccination programmes.

Dr KOBELA MBOLO (Cameroon) said that, after remaining poliomyelitis-free since 2009, Cameroon had reported four cases of poliomyelitis due to wild poliovirus since October 2013 and three further cases in January 2014. Her Government had declared a public health emergency and high-level political commitment had been harnessed. Actions forming part of the national emergency

plan included strengthening routine vaccination programmes, including reaching children in inaccessible areas and refugees in border areas, enhancing epidemiological surveillance, particularly at the community level, and coordinated response programmes with neighbouring countries, and six vaccination campaigns which had principally targeted children under the age of five. The Prime Minister would launch a further campaign at the end of May 2014. In the following month, mandatory vaccinations would be introduced for travellers leaving Cameroon, and visitors from other countries were expected to be vaccinated. With support from all partners, Cameroon was committed to tackling and eradicating poliomyelitis and had already issued a tender for the introduction of one dose of inactivated poliovirus vaccine into routine immunization programmes in April 2015.

Dr ACENG (Uganda), speaking on behalf of the Member States of the African Region, acknowledged the report, which provided a road map for action towards the goal of eradication. She appreciated WHO's leadership, the work of the Strategic Advisory Group of Experts on immunization, and the continued support of partners. She acknowledged national efforts in affected countries, in particular the high-level political commitment shown and additional funding that had been made available. As a result, new and reported cases in the Region had reached their lowest level in February 2013, but insecurity had led to a resurgence of the disease in some countries. She therefore called for continued support in the implementation of global and national initiatives. Given the risk of cross-border importation of wild poliovirus, she welcomed the intensive schedule of supplementary immunization activities in the 30 countries at highest risk. Sustained community mobilization was needed to support poliomyelitis eradication initiatives, and implementation of new and existing leadership structures to enhance societal acceptance of immunization was recommended.

It was essential to ensure the timely global withdrawal of the type 2 component of the oral polio vaccine from routine immunization programmes. She strongly supported WHO's engagement with vaccine manufacturers and regulatory agencies to improve the affordability and availability of the inactivated poliovirus vaccine. The work to support the transfer to developing countries of new production technologies for the inactivated poliovirus vaccine using Sabin polioviruses was important and would enable more countries to produce the vaccine at the national level. Partners and donors should support national efforts to establish a supply and funding strategy for timely introduction of the vaccine, using existing full-dose products during the transition period.

Dr KUMAR (India), speaking on behalf of the Member States of the South-East Asia Region, reported with pride that the Region had been certified as poliomyelitis-free on 27 March 2014. The concerted efforts of all countries, together with the resilience and dedication of poliomyelitis health workers, the sustained support of partners, including WHO, UNICEF and Rotary International, and the support and engagement of parents had enabled the Region to achieve certification in the face of significant challenges. Nevertheless, Member States remained mindful of the continued risk of poliomyelitis transmission and were committed to mitigating that risk. The need for sustained and intensified efforts to maintain the status must be taken into account in the Polio Eradication and Endgame Strategic Plan 2013–2018. As at 26 March 2014, all Member States in the Region had completed phase 1 poliovirus containment activities, with one specialized laboratory holding wild poliovirus materials and 68 biomedical laboratories holding potentially infectious materials.

He reaffirmed the Region's commitment to implementing the Polio Eradication and Endgame Strategic Plan 2013–2018 through national immunization technical advisory groups and application of adequate measures against possible importation of the virus. Expressing concern that global supply of the inactivated poliovirus vaccine might not match demand generated through the Plan, he sought information on any mitigation plans drawn up by WHO. He requested the continued regional support of all partners and donors and cautioned against complacency. The experiences of the Region had demonstrated that poliomyelitis could be eradicated; concerted efforts from the global community could lead to its eradication worldwide.

Dr TARAWNEH (Jordan) said that his country had been polio-free since 1992 but accepted that the risk of further international spread remained high; indeed, the Regional Committee for the Eastern Mediterranean had declared polio transmission an emergency for all Member States of the Region. Jordan was hosting some 1.5 million refugees from neighbouring countries and had conducted three national polio campaigns targeting some two million children under five years of age, including those in refugee camps, with the Ministry of Health shouldering the full costs. It was also committed to administering inactivated polio vaccine as part of its national immunization programme. Its hope was that bodies such as the GAVI Alliance would examine the possibilities for supporting the purchase of that vaccine at the lowest possible cost. Jordan was also strengthening its national surveillance system, particularly in the camps.

Mr RUIZ MATUS (Mexico) recognized the importance of implementing eradication strategies and establishing effective surveillance and accountability mechanisms. Mexico had issued warnings to travellers visiting countries where poliomyelitis was endemic or those with reported cases, emphasizing the need for prior vaccination and observation of appropriate hygienic measures. In 1994, PAHO had certified the country as free from wild poliovirus. He urged Member States to maintain high vaccination coverage, surveillance and early warning systems, and to implement containment measures in order to interrupt transmission of poliovirus.

Dr RATIH (Indonesia) said that, although the South-East Asia Region had been certified poliomyelitis-free, efforts to maintain high vaccination coverage and acute flaccid paralysis surveillance must be sustained until the disease was eradicated worldwide. Indonesia's poliovirus action plans, which were aligned with the Global Poliomyelitis Eradication Initiative, included measures to enhance protection through strengthened immunization programmes and eventual withdrawal of the type 2 component of the oral polio vaccine. In 2015 Indonesia planned to introduce one dose of inactivated poliovirus vaccine into its routine immunization schedule and in 2016 to switch from trivalent to bivalent oral polio vaccine. Indonesia was at high risk of transmission of poliovirus imported from affected countries; early detection and response remained vital. A national preparedness and response plan had been put in place to control outbreaks of wild poliovirus.

As part of the global response protocol, WHO should coordinate and maintain a polio vaccine stockpile, to which Indonesian vaccine production could contribute. She strongly encouraged all disease-affected Member States to implement immediately emergency measures to overcome the remaining obstacles to immunization of all children. The International Health Regulations (2005) should require systematic poliomyelitis vaccination of travellers entering and leaving affected countries.

Ms IBRAHIM (Maldives), highlighting her country's robust immunization programmes, which covered more than 95% of the population, said that Maldives had remained poliomyelitis-free since 1984. She shared the pride at the South-East Asia Region's certification of poliomyelitis eradication and encouraged affected countries in other regions to strive to reach the same goal. The Region was implementing the Polio Eradication and Endgame Strategic Plan 2013–2018 in spite of numerous challenges, including large population size, disease burden, poverty and inaccessibility, and the difficulties in applying the recommendation of the Strategic Advisory Group of Experts on immunization to introduce inactivated poliovirus vaccine into routine immunization programmes. Continued resource mobilization was crucial in order to enhance surveillance, vaccination coverage and supplementary immunization activities and to enable sustained progress. She thanked UNICEF for its support in vaccine procurement and the Director-General for her leadership. The development of a framework to support legacy planning at the national and local levels was keenly awaited. Notwithstanding the success achieved, there was no room for complacency; interregional cooperation must be strengthened in order to realize the shared vision of global poliomyelitis eradication.

Dr ATTAYA LIMWATTANAYINGYONG (Thailand) welcomed the South-East Asia Region's poliomyelitis-free certification, but expressed concerns. The risk of a possible spread of wild poliovirus to unaffected countries demanded continued and intensified efforts from all countries and regions. The global supply of inactivated poliovirus vaccine was limited and might result in interruption of programmes; she requested information about the number of WHO pre-qualified inactivated poliovirus vaccines in production and a timescale for their availability and about possible mitigation plans. Wastage rates of the inactivated poliovirus vaccine, if similar to those seen with multi-dose vials of other vaccines currently in use, would significantly drain programme resources; the cheapest purchase might be a false economy. WHO should accelerate eradication interventions in endemic countries, encourage good-quality surveillance, sustain high coverage with inactivated poliovirus vaccine in unaffected countries, intensify efforts to increase the number of pre-qualified generic inactivated poliovirus vaccines, and assess the optimum vial size in relation to the number of children to be vaccinated.

Ms REITENBACH (Germany) noted with great alarm WHO's declaration of a public health emergency of international concern following the recent outbreaks of poliomyelitis. She called on combatants in areas of civil conflict or strife to recognize the non-partisan nature of poliomyelitis, which was a global threat. The Global Polio Eradication Initiative, to which Germany remained committed, must be implemented by all Member States; all countries must undertake actions to augment health system resources and capacities to deal with that threat.

Mrs MELNIKOVA (Russian Federation), expressing concern at the rising number of cases of poliomyelitis and the widening spread of wild poliovirus, welcomed WHO's recommendations for the vaccination of travellers. Governments of affected countries must implement immediate emergency measures and assume full responsibility for national eradication programmes, which should include full-scale vaccination and high-quality surveillance. As all countries had to strengthen surveillance and environmental containment activities, WHO should formulate appropriate guidelines. Governments must also take comprehensive measures to prevent targeted attacks on health workers conducting vaccination programmes. Support should be provided to low-income countries in implementing the recommendation to introduce at least one dose of inactivated poliovirus vaccine into routine immunization programmes. With the engagement of all partners, work to further reduce the cost of the inactivated poliovirus vaccine must continue.

Dr USHIO (Japan), expressing appreciation of the work in implementing the Polio Eradication and Endgame Strategic Plan 2013–2018, noted with satisfaction the large decreases in cases of poliomyelitis in Nigeria and Afghanistan in spite of increases elsewhere. The deteriorating security situation in Pakistan cast doubt on its full implementation of the immunization programme. The declaration of a public health emergency of international concern should promote the taking of further control measures. Countries in which poliomyelitis was endemic must take further measures but other countries had to maintain high vaccination coverage rates, enhancing regular immunization programmes, strengthening health systems and increasing awareness of immunization, through high-level political commitment. Steps were needed to ensure effective legacy planning, in order to adapt the lessons from poliomyelitis to other diseases. Japan pledged continued commitment to eradication.

Mr TAAPE (Tuvalu) thanked WHO for support in the implementation of immunization programmes and the procurement of vaccines and many Member States and other partners for their support in terms of funding, human resource development and procurement of medical equipment. Chinese Taipei had demonstrated its willingness to engage in efforts to improve people's welfare across the world and he therefore urged WHO to facilitate Chinese Taipei's broader participation in its meetings, activities and mechanisms based on the established model for participation in the Health Assembly.

Dr Jih-Haw CHOU (Chinese Taipei) said that, even though Chinese Taipei was poliomyelitis-free, surveillance activities had been expanded and consolidated. Reporting of enterovirus infections with severe complications was mandatory. To prepare for withdrawal of the type 2 component of oral polio vaccine by 2016, Chinese Taipei had been including pentavalent vaccine containing inactivated poliovirus antigen in routine immunization programmes for preschool children since 2010 and in 2012 replaced oral polio vaccine with inactivated poliovirus vaccine for schoolchildren and people travelling to affected areas. He called on WHO to ensure a stable supply of inactivated poliovirus vaccine to guarantee the sustainability of immunization programmes and affirmed his country's commitment to the goal of global poliomyelitis eradication.

Ms DIMENT (Rotary International), speaking at the invitation of the CHAIRMAN, recognized the progress made as a result of implementation of the Polio Eradication and Endgame Strategic Plan 2013–2018. Nevertheless, the increase in cases in 2013 showed that work was still needed. Rotary International fully supported the decision to enact recommendations through the International Health Regulations (2005) and urged poliomyelitis-affected Member States to ensure their full implementation to prevent further international spread of poliovirus, with the support of unaffected countries. Advances had been made in Nigeria, but the full commitment of partners and officials at all levels, together with high-quality activities, would be vital to interrupt transmission. She called for full access to poliomyelitis vaccination for all children and secure conditions for health workers. The switch from the oral to inactivated poliovirus vaccine would need Member States' engagement and she urged countries to develop a plan for introducing at least one dose of inactivated poliovirus vaccine into routine immunization programmes by the end of 2014. Complete and timely fulfilment of pledges was essential and she applauded Member States that had met and even increased their financial commitment to the Strategic Plan.

Ms SLOATE (GAVI Alliance), speaking at the invitation of the CHAIRMAN, welcomed the progress made towards poliomyelitis eradication in the face of significant challenges, including the deplorable violence against health workers. The introduction of a single dose of inactivated poliovirus vaccine into routine immunization programmes would improve immunity to poliomyelitis, help to prevent the emergence of vaccine-associated outbreaks and hasten eradication of wild poliovirus. It was essential to strengthen routine immunization programmes, as emphasized in 1988 in resolution WHA41.28 on the global eradication of poliomyelitis. The GAVI Alliance was working intensively to facilitate routine immunization of all children, for instance by providing financial support for health system strengthening, increasing vaccination coverage and improving access to primary health care services; 73 countries were eligible for funding through the Alliance to support introduction of inactivated poliovirus vaccine. Collaboration with UNICEF and vaccine manufacturers should ensure a reliable supply of inactivated poliovirus vaccine sufficient to meet country demand at prices as low as about US\$ 1 per dose. Given the priority of global poliomyelitis eradication, the GAVI Alliance Board had agreed to allow countries ceasing to be eligible for support from the Alliance and countries with less than 70% routine coverage to request support for introducing inactivated poliovirus vaccine. Already, 26 countries had applied for that support. The GAVI Alliance offered continued and enhanced collaboration in implementing the Global Polio Eradication Initiative.

Dr AYLWARD (Assistant Director-General) commented on the historic nature of the discussion on poliomyelitis. Replying to Member States' questions, he said that WHO's international coordination of, inter alia, technical and financial support for polio eradication activities was being significantly enhanced, as exemplified by the meeting convened two days previously by the Regional Director for the Eastern Mediterranean to coordinate action regarding the situations in Afghanistan, the Horn of Africa, the Middle East and Pakistan and the meeting convened the day before by the Regional Director for Africa for the Central African Member States and Nigeria to ensure that support to interrupt transmission was further intensified. WHO would continue to strengthen outbreak preparedness and response measures in coordination with Member States. WHO and all its partners

were working in much closer collaboration to accelerate actions on routine immunization programmes, including introduction of inactivated poliovirus vaccine. With regard to environmental surveillance, WHO would be rolling out a comprehensive strategy and standards in 2014, with a specific plan for high-risk areas regarding the emergence and international spread of vaccine-derived poliovirus type 2.

Following a thorough review by WHO and many partners, including UNICEF, the GAVI Alliance and the Bill & Melinda Gates Foundation, sufficient supply for the timely introduction of the inactivated poliovirus vaccine, as recommended in the Polio Eradication and Endgame Strategic Plan 2013–2018, could be assured. It was imperative that Member States establish by the end of 2014 a plan for introducing that vaccine into their routine immunization programmes in order for supply to be managed in consultation with vaccine manufacturers. One manufacturer had offered to produce prequalified vaccines at a historically low price of US\$ 1.00 per dose for countries eligible for support from the GAVI Alliance and two manufacturers had offered prices to middle-income countries, one for as little as US\$ 1.90 per dose. He recognized the need to accelerate work to ensure supply of five-dose vials, which would be available from one manufacturer in late 2014 and from a second one in 2015. Noting that Member States clearly accorded high importance to vaccine self-sufficiency, he confirmed that a technology transfer project for inactivated poliovirus vaccine produced from the Sabin strain had been initiated, thereby enabling public-sector producers in key developing countries to manufacture the vaccine. Considerable work had been undertaken to put in place a mechanism to provide financial support to low- and middle-income countries in introducing inactivated poliovirus vaccine and UNICEF had devised a plan to ensure pooled procurement of the vaccine at the lowest possible price.

The vision set out in the Polio Eradication and Endgame Strategic Plan 2013–2018 had proven to be robust, and tangible progress had been made: no wild poliovirus type 3 had been detected since November 2012; transmission was close to being interrupted in Africa; and the outbreaks in the Eastern Mediterranean Region were abating. He thanked Member States and partners including, in particular, Rotary International, for their commitment to achieving the goals set out in the Endgame Strategic Plan. It was to be hoped that by the Sixty-eighth World Health Assembly there would be one less poliomyelitis-infected continent and one less poliovirus to deal with and that the goal of global eradication would be more achievable than ever.

The DIRECTOR-GENERAL expressed appreciation for Member States' ongoing efforts, including their political commitment, national ownership, recognition of the importance of immunization strategies and integration of the Global Polio Eradication Initiative into national programmes. Such efforts had been carried out with essential support from partner organizations. She encouraged all regions, through the leadership of the regional directors, to continue working in close collaboration, sustain efforts and implement the Polio Eradication and Endgame Strategic Plan 2013–2018 in order to eradicate poliomyelitis.

The Committee noted the report.

The meeting rose at 17:35.

TENTH MEETING

Friday, 23 May 2014, at 18:05

Chairman: Professor PE THET KHIN (Myanmar)

1. WHO REFORM: Item 11 of the Agenda (continued)

Framework of engagement with non-State actors: Item 11.3 of the Agenda (Documents A67/6 and A67/54) (continued from the second meeting, section 2)

Dr DAHL-REGIS (Bahamas), speaking in her capacity as chairman of the drafting group that had been convened, said that it had agreed on a draft decision for consideration, which read as follows:

The Sixty-seventh World Health Assembly, having considered the report on the framework of engagement with non-State actors;¹ welcoming the progress made on the draft framework of engagement with non-State actors by the Sixty-seventh World Health Assembly; underlining the importance of an appropriate framework for engagement with non-State actors for the role and work of WHO; and recognizing that further consultation is needed on issues including conflict of interest and relations with the private sector,

- (1) called upon Member States to submit their specific follow-up questions to the Director-General by 6 June 2014;
- (2) requested the Director-General:
 - (1) to prepare a report in response to the Health Assembly's comments and the follow-up questions raised;
 - (2) to consult further with Member States during the regional committees, in 2014 on the basis of the draft framework of engagement with non-State actors and the report referred to in subparagraph (2)(1) above;
 - (3) to submit an account of the further consultations undertaken in 2014 and the proposed way forward to the Executive Board at its 136th session in January 2015.

Mr BOISNEL (France), supported by Professor BOA (Côte d'Ivoire), welcomed the draft decision, which reflected accurately the conclusions reached by the drafting group.

Mr KLEIMAN (Brazil) said that the proposed deadline of 6 June did not allow Member States sufficient time to submit follow-up questions; he requested an extension to at least 24 June. The report referred to in subparagraph 2(1) should be substantive, and deal with the comments and questions of Member States.

He sought clarification on how the outcome of the regional committees' consultations would be taken into account in the final decision.

¹ Document A67/6.

Dr DELGADO (Bolivarian Republic of Venezuela) supported the comments of the delegate of Brazil, adding that the further consultation mentioned in the preambular paragraph should address the whole document and not just issues such as conflict of interest or relations with the private sector.

Mr PUSP (India) agreed that more time was needed for the submission of follow-up questions and that more clarity was required on the process of consultation with the regional committees.

Mr ROSALES LOZADA (Plurinational State of Bolivia) proposed amendments to the draft decision: the title should be changed to make clear that it had originated in a drafting group and the consultations mentioned in the preambular paragraph should be broader in scope but not excluding conflicts of interest. The deadline set in paragraph 1 was too short for Member States to submit follow-up questions.

The report referred to in subparagraph 2(1) should not be simply a response to Member States' comments but also provide clarification from the Secretariat on issues raised. The deadline for circulation of the documentation referred to in subparagraph 2(3) should be brought forward to November 2014 in order to allow Member States sufficient time to review it before the January session of the Executive Board.

He asked whether it might be useful to continue the work in an informal drafting group.

Ms POLACH (Argentina) broadly supported the views expressed by the delegates of the Plurinational State of Bolivia and Brazil, although it would be preferable for the report prepared pursuant to subparagraph 2(1) be issued some time before the regional committees' meetings. She favoured completing the work in an informal drafting group.

Professor HALTON (Australia) agreed that the draft decision fairly reflected the extensive discussions in the drafting group. The deadline of 6 June was too short and the report requested in subparagraph 2(1) should be comprehensive. She asked the Director-General to clarify the intended method of work in respect of the actions requested in paragraph 2. The documentation referred to in subparagraph 2(3) should be brought forward to November 2014 so as to allow time for Member States to consider it in depth. She was not convinced of the need for an informal drafting group as the draft decision comprised requests to the Director-General.

Ms PADILLA RODRÍGUEZ (Mexico) agreed with the proposals made by previous speakers, including the proposal for an informal drafting group to finalize the draft decision. As engagement with non-State actors was a key part of the reform process, it was important for Member States to reach consensus.

The DIRECTOR-GENERAL thanked speakers for their interventions. It would be necessary to establish how far the very reasonable requests they had made could be fulfilled in reality. The dates of the meetings of the six regional committees, which had already been set and could not be moved, would have a bearing on the timetable of work. On the other hand, it should be possible to defer the deadline for submission of follow-up questions to 24 June 2014.

She agreed that consultations should be extended beyond the issues of conflict of interest and relations with the private sector. That possibility had been foreseen in the use of the words "on issues including" in the draft decision. She encouraged Member States to raise additional issues with the Secretariat.

Ms PADILLA RODRÍGUEZ (Mexico) said that, even though the draft decision reflected well the discussions held, it would be beneficial for Member States to have additional time to consider the text and to propose any final amendments.

The DIRECTOR-GENERAL, responding to the delegate of Brazil, confirmed that a more substantial report responding to points raised could be produced. The work would necessarily be guided by the questions submitted by Member States, but the Secretariat would endeavour to provide as much analysis as possible in order to meet their expectations.

Regarding the methodology for the regional discussions and consultations, she recalled that the last of the six regional committee meetings was usually held at the end of October and the normal mechanism would be for the Health Assembly to request the six regional committees to place an item on their meeting agendas so that all Member States had the opportunity to express their opinions. That process was inclusive and she therefore preferred it to the option of holding meetings in Geneva which some delegations would not necessarily be able to attend. The Health Assembly could request in the draft decision that regional directors should include an item on engagement with non-State actors in the committees' provisional agendas. The basis for discussions would be the original report (document A67/6) and the report containing the responses to Member States' follow-up questions.

The documents would need to be sent to Member States by the first week of August so that there would be time to review them before the regional committee meetings began in September, meaning that she and her colleagues would have just over four weeks from 24 June to respond to the follow-up questions.

Mrs ROSE-ODUYEMI (Office of Governing Bodies) said that, in order for the document to be disseminated in all six languages during the first week in August, it would need to be made available for translation by mid-July.

The DIRECTOR-GENERAL proposed that the deadline for the submission of follow-up questions be moved to 17 June so that there would be adequate time for translation before the report was circulated.

The final regional committee meeting was scheduled to end on 22 October 2014. The Secretariat would need six weeks to consolidate the outcomes of all six regional committee meetings, which meant that the document would not be available to Member States until about 10 December 2014.

Ms POLACH (Argentina) said that she had requested an amendment to the draft decision that would provide for the documents to be made available before the regional committee meetings and she had suggested that they could be posted on the WHO website.

The DIRECTOR-GENERAL, continuing her explanation, said that the document to be considered by the Executive Board at its 136th session in January 2015 would be made available in December 2014. As the session of the Board was preceded by a meeting of its Programme, Budget and Administration Committee, there would be insufficient time to hold the informal consultations that some delegations had requested, but it should instead be possible to conduct briefing sessions with the permanent missions in Geneva.

Mrs NAARENDORP (Suriname) requested that the outcomes of the regional committee consultations be made available to Member States as an official document at the Sixty-eighth World Health Assembly.

Mr ROSALES LOZADA (Plurinational State of Bolivia) accepted the timeline suggested by the Director-General. If informal consultations could not be held before the 136th session of the Executive Board, the proposed briefing sessions would be of value. His concern was that Member States might request the convening of a further working group to consult on issues that had not been fully discussed by the Executive Board; if matters could be dealt with by the Executive Board, the question of a further working group would not arise.

Subparagraph 2(1) of the draft decision referred to a report to be produced by the Secretariat in response to questions raised by Member States. In the drafting group's discussions, however, delegations had indicated firm positions on certain issues; how would they be dealt with in the report?

The DIRECTOR-GENERAL said that the draft decision could be amended to accommodate the request by the delegate of Suriname that the outcome of the regional discussions be submitted in a formal report to the Health Assembly. Responding to the delegate of the Plurinational State of Bolivia, she recalled that there had been many statements on the agenda item and that Member States had made clear their concerns regarding, inter alia, the need to strengthen the mechanism for dealing with conflicts of interest. Subparagraph 2(1) provided for the preparation of a report in response to Member States' comments and follow-up questions and all comments submitted to the Secretariat by 17 June 2014 would be included.

Mr ROSALES LOZADA (Plurinational State of Bolivia) said that it had been noted in the drafting group that many of the Organization's practices had grown up over time and some of them needed to be improved or corrected. Was the Secretariat going to justify those practices or propose a course of action? Member States needed clarity on that matter, as it would influence the way in which they would submit questions in the future.

Dr DAHL-REGIS (Bahamas) said that all the comments and questions put forward by Member States during the drafting group had been noted and passed to the Secretariat.

The DIRECTOR-GENERAL said that, as there had been no formal record of the discussion in the drafting group, the delegate of the Plurinational State of Bolivia might wish to submit all its comments as follow-up questions before 17 June 2014.

Ms PADILLA RODRÍGUEZ (Mexico) acknowledged the progress made by the drafting group. Although Member States had held fruitful discussions on the general framework and specific proposals for policies and procedures regarding non-State actors, the entire document would require careful revision before agreement could be reached. Governance reform was a crucial way of strengthening the Organization and WHO should endeavour to advance efficiently, patiently and comprehensively. Her delegation had proposed the establishment of an open-ended working group in order to give appropriate follow-up to the discussions on the governance agenda and allow a consensus to be reached on reform. She welcomed the regional consultations proposed by the Director-General and did not wish to disrupt the proposed timetable.

Dr WARIDA (Egypt) noted that the issue had been discussed several times, including at the level of the Eastern Mediterranean Region. He welcomed the bottom-up approach contained in the draft decision, with discussions moving from country to regional and then global level. His understanding was that the overall cost of convening a working group was US\$ 1 million, which would make it an expensive solution and would prevent WHO from exploring a bottom-up approach. He therefore proposed that the Organization should try the bottom-up approach and could make a decision on it in January 2015 at the 136th session of the Executive Board.

Ms BLACKWOOD (United States of America), agreeing with the previous speaker, emphasized that all the components of the draft decision reflected agreement reached in the drafting group. The draft decision requested the Secretariat to accomplish a significant amount of work and it would be assisted if follow-up questions could be submitted as early as possible. The opportunity provided in paragraph 1 of the draft decision should be used to the full by those with questions and concerns. She noted that the intention, supported by her delegation, was to bring the item back for consideration by the Sixty-eighth World Health Assembly. The Executive Board could before then

determine how to proceed. It was to be hoped that all the activity on the issue would help to build consensus towards adoption of the decision in 2015.

Mr LINDGREN (Norway) expressed strong support for the statements made by the delegates of Egypt and the United States of America.

Mr BOISNEL (France) agreed with the preceding speakers. The collective efforts of Member States and the Secretariat had resulted in the proposal that follow-up questions could be submitted in writing – a method that was a great deal more workable and accessible than an intergovernmental mechanism which, past experience had shown, was a costly exercise that was rarely attended by more than half the Member States. Therefore, he favoured the simple and effective approach proposed which would allow the Secretariat to compile a summary that could be discussed by the Executive Board and adopted by the Sixty-eighth World Health Assembly.

Ms KUIVASNIEMI (Finland) supported the statements made by the delegate of Egypt and other preceding speakers. It was important to use the governing bodies and to try to avoid extraordinary measures. The Director-General had reminded the Committee that intergovernmental meetings did not usually have full participation. Using the governing bodies would provide better opportunities for all Member States to participate. Furthermore, as the costs of an intergovernmental working group were not included in the Programme budget 2014–2015, such a process could only begin in 2016.

The DIRECTOR-GENERAL, noting the work planned until January 2015, suggested that delegations might consider the proposal by the delegate of Egypt. Bottom-up approaches were important and an inclusive process would accommodate the concerns of smaller countries that had less capacity. She asked the delegations of Brazil, Argentina, the Bolivarian Republic of Venezuela, India, the Plurinational State of Bolivia and Mexico whether they could support the more streamlined process that would lead to further discussion in January 2015.

Ms PADILLA RODRÍGUEZ (Mexico) acknowledged that there had been no consensus on the proposal to establish an intergovernmental open-ended working group but it had still been important to table it in the Committee for consideration by Member States. Once the proposed amendments had been incorporated in the draft decision, there would be no need to hold lengthy discussions as it would then be ready for adoption.

The DIRECTOR-GENERAL said that, if the Committee was in agreement, she would ask the Secretariat to revise the draft decision on the framework of engagement with non-State actors. The preambular paragraph would remain unchanged, given her explanation of the word “including”, which did not mean that only the two issues referred to could be discussed. In paragraph 1, the date given would be amended to 17 June. The requests set out in paragraph 2 would be amended and a specific timeline would be laid down for the provision of documents. Those amendments would provide greater clarity and the text could then be redistributed to Member States.

Ms PADILLA RODRÍGUEZ (Mexico) agreed with the comments by the Director-General. She requested that the word “working” should be replaced by “drafting” in the title of the decision. The last part of the preambular paragraph should conclude with the words “and recognizing that further consultations and discussions are needed”.

The DIRECTOR-GENERAL asked the delegate of Mexico whether she could accept the retention of the phrase “on issues including conflict of interest and relations with the private sector” since those issues had been provided as examples.

Ms PADILLA RODRÍGUEZ (Mexico) said that she would prefer to stop the sentence at “are needed”, but, given the Director-General’s explanation, could accept the inclusion of the rest of the sentence.

Ms POLACH (Argentina) said that she would prefer the sentence to end at the words “are needed”, without listing any of the specific issues. The consensus following drafting group discussions had been much broader than the two issues outlined in the final part of the sentence.

Dr DAHL-REGIS (Bahamas) said that the wording in the draft decision had been agreed in the drafting group by those present in the drafting group.

The DIRECTOR-GENERAL requested that delegations should adopt a flexible approach. The list of issues in the preambular paragraph on which Member States would continue to consult was not exhaustive since it was prefaced by the word “including”.

Ms POLACH (Argentina) reiterated that discussion of the whole document was required.

The CHAIRMAN took it that the Committee wished the Secretariat to produce a revised version of the draft decision.

It was so agreed.

(For continuation of the discussion and approval of the draft decision, see the summary record of the twelfth meeting, section 4.)

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

Newborn health: draft action plan: Item 14.2 of the Agenda (Documents A67/21 and A67/21 Corr.1) (continued from the ninth meeting, section 2)

The CHAIRMAN invited the Committee to resume its consideration of the draft resolution proposed by Cameroon, Canada and Malawi.

Dr NDOUNDO (Chad), speaking on behalf of the Member States of the African Region, said that more than one quarter of the four million newborn deaths each year occurred in the Region, most in the first week of life due to prematurity, hypoxia or infections. The draft action plan on newborn health aimed to eradicate newborn deaths due to preventable causes by 2035. Countries should establish good governance for the plan and provide effective reproductive, maternal and neonatal health care services with the participation of the community and in coordination with development partners. Quality care was provided by integrating services and coordinating approaches with the health care system. The action plan was ambitious but realistic. The East Africa subregion was the area with the highest number of neonatal deaths and it had few of the required capacities to implement the plan. Indeed, the challenges were enormous and included the low number and quality of human resources and a lack of registrars to register births and record neonatal and maternal deaths and stillbirths. Various threats to implementation of the plan existed, including political instability, conflict and natural disasters. Nonetheless, with the participation of communities, where education and information were essential to demanding quality care, it was possible that the noble objectives of the plan could be achieved by 2035. He called for the adoption of the draft action plan and the draft resolution, and had submitted a document containing proposed amendments to the text.

Ms BALAS (Germany) supported the draft action plan and was pleased to cosponsor the draft resolution. She also supported strengthening health systems and integrated maternal, newborn and child health services based on a continuum of care. Germany was contributing €400 million to the implementation of the Muskoka Initiative and the Global Strategy for Women's and Children's Health through the Initiative on Rights-based Family Planning and Maternal Health, which supported the training of health workers, particularly midwives, and promoted access to modern family planning and professional care during pregnancy and birth. The interventions proposed in the action plan already formed part of her country's global health policy and programmes. Adoption of the draft plan was essential to ensuring a focus on maternal, newborn and child health in the post-2015 development agenda.

Dr SIMA (Ethiopia) supported the draft resolution and welcomed the comprehensive action plan, although she proposed that it should include some measureable goals for reducing maternal mortality and improving family planning. They could be aligned with the recent global move to end preventable maternal deaths and Family Planning 2020 initiatives on access to services. The clear inclusion of community health workers in the action plan was commendable, as their engagement could contribute significantly to improving health-seeking behaviour in communities and leading to people taking action for their own health. Developing countries could learn from the Ethiopian community health worker programme that had used cost-effective, integrated approaches to tackle maternal and newborn health issues in a resource-limited setting, and consider using that platform for newborn health improvements. The draft action plan was well aligned with Child Survival Call to Action; although most of the commitments made by the African leadership on the Child Survival Call to Action had been included, further prioritization and emphasis were needed to identify and tackle critical factors beyond health programmes, such as girls' and boys' education, empowering women and men, and inclusive economic growth.

Dr Y. PILLAY (South Africa) supported the draft action plan, including the proposed targets, noting that it was an area where the least progress had been made globally. Neonatal morbidity and mortality could not be reduced without a focus on newborn health, the political leadership required, a robust plan and the necessary resources. The continuum of care and six key interventions in the action plan were not new but the way in which the plan had been drafted provided the necessary focus on the interventions that should be prioritized. South Africa had taken steps to improve newborn health with a focused programme led by a neonatologist that had already shown promising results. He supported the draft resolution.

Ms CHASOKELA (Zimbabwe) proposed the following amendments to the newborn health draft action plan. In paragraphs 9 and 41, she proposed amending the words "where every pregnancy is wanted" to "where every pregnancy is cared for", as it was important to imply that pregnancy was cared for in order to ensure the survival of the newborn. In paragraph 18, she proposed deleting the word "newborn" before "child", since the Convention on the Rights of the Child gave children rights both before and after birth. In paragraph 35, she proposed replacing the words "Contraception is a vital contributor" to "Family planning is a vital contributor", because it was the sovereign right of each Member State to determine its mode of family planning. In paragraph 45, she proposed recasting the wording of strategic objective 1 from "strengthen and invest in care during labour, birth and the first day and week of life" to "strengthen and invest in care from pregnancy and the first 1000 days, particularly focusing on care during labour, birth and the first day and week of life." She proposed adding at the beginning of paragraph 47, "The first two trimesters of pregnancy are important, and special focus is needed in" and therefore deleting "is especially important" later in the sentence. In both subparagraph (i) in the box following paragraph 83 and paragraph 90, she suggested adding "in line with national jurisdiction" after the words "targeted programmes". Finally, in paragraph 90, she suggested replacing the word "comprehensive" with "good-quality".

Professor CHOMBA (Zambia) noted that most newborn deaths occurred around childbirth or were due to causes stemming from inadequacies in care during childbirth, and she welcomed the focus of the action plan on improving newborn care. However, any policy focusing on maternal or newborn health should include the health needs of both groups in an integrated fashion. Zambia had managed to reduce maternal mortality by 51% between 1990 and 2013 and child mortality to 50 per 1000 live births by 2012. It had also paid special attention to integrating reproductive health services with HIV. In order to end preventable newborn morbidity and mortality, women should be healthy throughout their reproductive period, a goal that could be achieved through linkages with community programmes centred on empowerment, literacy and conditional cash transfers. She wished to see targets for ending preventable maternal deaths alongside those for preventable newborn deaths in the action plan.

Dr BRYANT (Australia) appreciated WHO's efforts to raise the profile of neonatal mortality and supported approval of the draft action plan. Her country wished to cosponsor the draft resolution, subject to two amendments: in subparagraph 2(4), the words "reporting every second year to the Health Assembly" should be replaced by "sharing information" in order to allow Member States flexibility in sharing information. In addition, in subparagraph 3(3), the words "every second year" should be replaced by "periodically", to give the Director-General the flexibility to decide when to report to the Health Assembly.

Ms CHO Soo-nam (Republic of Korea) said that newborn health protection was central to achieving Millennium Development Goal 4 (Reduce child mortality). Member States should provide quality health care to mothers and newborns close to their homes and, in particular, establish obstetric care systems for high-risk newborns. Recognizing the link between high newborn mortality rates and malnutrition, the Republic of Korea was implementing the comprehensive implementation plan on maternal, infant and young child nutrition, approved by the Sixty-fifth World Health Assembly in resolution WHA65.6. It had introduced a day celebrating expectant mothers in order to improve social awareness of childbirth and created a newborn health management index to assess the impact of economic and social factors on newborn health.

Dr MMBANDO (United Republic of Tanzania) welcomed the introduction of the newborn health draft action plan because, although his country had made remarkable progress in child survival, newborn survival was improving at a slower pace. He would support the draft resolution, as amended by the delegate of Zimbabwe. He further proposed that, in the text proposed by the delegate of Cameroon in the previous meeting, the words "is within reach and that its achievement" should be deleted in the fifth preambular paragraph; and, in subparagraph 2(2), the words "but not limited to" should be deleted, and the word "child" should be replaced by "newborn".

Ms ALVEBERG (Norway) said that the action plan had been greatly improved through consultations; it provided an excellent summary of current evidence of approved actions to improve neonatal care. Nevertheless, despite being comprehensive, it could include more specific advice on how to proceed in countries with a high burden of neonatal mortality but poor capacity. It also required a rigorous accountability framework to ensure real action. She therefore encouraged the Secretariat to follow up on Member States' monitoring plans within 12 months of the action plan's adoption and to amend the draft resolution accordingly by adding the following subparagraph 3(2): "To prioritize the finalization of the more detailed monitoring plan with coverage and outcome metrics to track progress of the newborn action plan;".

Ms KENNY (Ireland), speaking on behalf of Austria, Botswana, Mongolia and Uruguay, said that 6.6 million children under five years of age died each year of preventable and treatable causes and nearly half of them were newborn babies. Mortality remained highest among children of poor and marginalized communities and was also driven by discrimination and social exclusion. For that reason, she appreciated the focus on human rights in the draft action plan, in line with the increasing focus on

human rights in the work of WHO, including the Health Assembly. Efforts to eliminate preventable newborn deaths required a comprehensive and holistic approach, explicitly recognizing and integrating relevant human rights standards. The Human Rights Council had rightly focused on how efforts against maternal mortality could benefit from the integration of human rights principles into policies at national and subnational levels, and it had pursued further work on mortality of children under five as a human rights concern. The human rights perspective stemmed from WHO's first-ever report to the United Nations Human Rights Council. Following a resolution brought by Austria, Botswana, Ireland, Mongolia and Uruguay in September 2013, technical guidance was currently being prepared on the practical application of a human-rights based approach to tackle mortality of children under five. The work, a collaboration between the Office of the High Commissioner for Human Rights and WHO, was a positive example of closer cooperation between the health and human rights communities. Such cooperation was essential for dealing with inequities concerning the right for all to the highest attainable standard of health. Once completed, the guidance should be used to inform and guide the implementation of the draft action plan.

Dr AL-TAAE (Iraq) suggested the following actions: using neonatal screening programmes to detect congenital metabolism defects; within the framework of Millennium Development Goals 4 (Reduce child mortality) and 5 (Improve maternal health), integrating all measures aimed at reducing the maternal mortality rate within those for children under five; intensifying efforts for high-risk newborns; focusing more attention on neonatal nutrition, starting exclusively with breastfeeding; and concentrating maternal and child health programmes on clean and safe delivery, high-risk pregnancies, breastfeeding and timely immunization programmes.

Dr SHAHANIZAN MOHD ZIN (Malaysia) agreed that newborn health could not be taken in isolation but as a component of integrated health services for reproductive, maternal, newborn, child and adolescent health and within a well-functioning health system involving sectors dealing with social determinants of health. Almost 40% of neonatal deaths in Malaysia were due to immaturity. In countries with low mortality rates, neonatal deaths could only be further reduced by investing in expensive secondary care services, such as neonatal intensive care units. Although she supported the draft resolution, the proposed indicators should be phased in order to allow time for capacity-building. In that way, indicators that currently did not exist could be assessed for consistency before implementation.

Dr KUMAR (India) said that India was pleased to cosponsor the draft resolution. The world was currently on the brink of a major breakthrough to guarantee the survival of newborns. In recent years, India had begun a major political movement to tackle newborn and child mortality, and had managed to reduce under-five mortality by more than 50% since 1990 and newborn mortality by 6% in the previous two years. To accelerate the progress on maternal, newborn and child health, India was fully committed to a continuum of care and bringing sharper focus to bear on adolescents and family planning. To ensure equitable health care, the worst 25% performing districts had been identified on a health index and were receiving higher per capita funding, enhanced monitoring, focused support supervision and harmonized technical support. Through its National Health Mission, India had also expanded services to reach every mother and newborn by empowering health workers, tackling demand-and-supply-related bottlenecks, and removing financial barriers to provide free services to all pregnant women and infants in public and accredited health facilities. Following its commitment at the 2013 Global Newborn Health Conference in Johannesburg, South Africa, his Government was finalizing the India Newborn Action Plan for newborns through consultations with all stakeholders.

Ms WANG Qiaomei (China) commended the Secretariat's work in coordinating the consultation process and concurred with the basic principles of the draft resolution. Her Government offered to provide economic indicators to assist the Secretariat and other Member States with the financing of the action plan. She also suggested that the Secretariat design short-, mid- and long-term

actions under the strategic objectives for reducing newborn mortality and that there should be differential priorities for those actions. She requested that expert discussions should be held on choosing and simplifying indicators.

Ms PALMIER (Canada) welcomed the action plan and said that it shed light on the unacceptable number of preventable newborn deaths. Although progress had been made in recent decades to reduce the number of child deaths worldwide, neonatal and newborn mortality rates had declined at a slower pace. With 2015 fast approaching and many countries lagging behind in progress towards the Millennium Development Goal 4 and 5 targets, the time was right to tackle preventable maternal and child deaths and clear bottlenecks with regard to newborn survival. Canada remained committed to ensuring global focus on maternal, newborn and child health in the post-2015 development agenda.

Mr ESIN (Russian Federation) said that his country had achieved Millennium Development Goals 4 and 5 and that newborn deaths and stillbirths were already below the target indicator set out in the action plan for the years 2030 and 2035. He proposed that the draft action plan be adopted but wished to propose some additions. When developing organizational activities to ensure access to quality care, the introduction of three-tiered system for perinatal care should be recommended. In paragraph 68, reference should be made to training health care workers using innovative instruction methods, such as simulation training and distance learning methods for professional development. In paragraph 138, in the part dealing with auditing the quality of care during birth, the following should be added: “auditing the care of newborns, for example an audit of the rational use of antibiotics, which should contribute to preventing antibiotic resistance in obstetric hospitals.” In paragraph 139, to the research priorities should be added research into optimal nutrition for pregnant women with delayed fetal development and sick newborns to prevent perinatal programming of noncommunicable diseases at a later stage.

Dr GNING (Senegal) welcomed the inclusion of newborn health on the agenda, noting that it was in keeping with the African declaration of commitment on maternal, newborn and child health. He supported the draft resolution. In his country, newborn health was promoted through national health policy, including work on product safety and awareness-raising. Research into the availability of obstetric and neonatal care from 2013 and a study in 2014 on newborn health would help to develop a comprehensive action plan for newborns. All initiatives that could speed up the implementation of interventions for newborn health should be encouraged.

Dr AL ABRIYA (Oman) applauded the comprehensive goals, principles and approaches of the draft action plan and their linkage with reproductive, maternal and newborn health. The Sultanate had implemented various strategies to achieve a considerable reduction in under-five mortality within a short space of time, enabling it to meet Millennium Development Goal 4. Completing a further reduction in neonatal mortality posed a major challenge, however, as genetic disorders and congenital malformations accounted for some 22% of total newborn deaths. Therefore, part of Health Vision 2050, the country’s maternal and child health strategy, included mortality-reduction measures consistent with the draft action plan. The Sultanate was also due to host a meeting of the WHO Eastern Mediterranean Region on antenatal care in November 2014. She endorsed the draft resolution, but proposed that subparagraph 2(2) be amended to read: “committing themselves, according to their capacities, to allocating adequate human and financial resources to improve the quality of health care and achieve the national newborn health targets in line with the global action plan”.

Dr ROSS (Solomon Islands), supporting the draft action plan, stated that in an era where human health was under threat from climate change, the contribution of health to social and economic development must not be left to chance. Health-related plans and actions should be informed by policy coherence across multiple sectors with the aim of improving health and health equity. The post-2015

development agenda, at the core of which should be newborn health, was already relevant and the Secretariat and Member States must factor planning and strategic allocation of resources into current budgets. New partnerships would need to be forged and he recognized the contributions towards enhancing medical care in his own country of many partners, including the WHO country office in Solomon Islands, UNICEF, UNFPA, Member States and other entities and organizations. In the post-2015 agenda, his country favoured a broader participation in WHO meetings and mechanisms and offered its expertise to contribute to the Organization's endeavours.

Mr BOISNEL (France) supported the adoption of the draft action plan, which was in keeping with the Global Strategy for Women's and Children's Health and responded to the recommendations on quality, accountability and better data from the report of the independent Expert Review Group in 2013. He shared the vision of a world where each woman, mother, newborn and child had access to quality care without risk of impoverishment and where their rights were respected. France was therefore acting to support States in improving maternal and child infant health. Some examples included: the share of the financial transaction tax that France allocated to paying for children's care in the Sahel; committing €60 million over the period 2010–2015 to efforts to reduce maternal and neonatal mortality in Africa and Haiti through the Muskoka Initiative; and annual contributions totalling €19 million to four United Nations agencies in order to focus on high impact activities, including health personnel training, integrated health care for children and birth spacing. France supported better coordination of work between United Nations agencies in order to promote integrated health care across the continuum of services for adolescents, women, mothers, newborns and children. Aware of the risks and inconveniences of a vertical approach, he said that all actions and interventions in reproductive, maternal, neonatal and infant health should be included in that continuum of care.

Ms SAMIYA (Maldives) praised the draft action plan, which would focus attention on Member States with a high burden of women and children's health problems and give impetus towards the attainment of Millennium Development Goals 4 and 5. In Maldives, child mortality had declined threefold in the previous decade and the challenge ahead was to tackle neonatal mortality. Currently 78% of infant deaths were among neonates, more than 80% in the first week of life, which warranted full commitment to the action plan. Sustaining achievement would be challenging for Member States with low rates of infant and neonatal mortality, but Maldives was prepared to rise to the challenge.

Ms SOVD TUGSDELGER (Mongolia) recalled that her country had cosponsored a resolution on preventable mortality and morbidity of children under five years of age, adopted at the United Nations Human Rights Council in September 2013. The resolution had set out a human rights-based approach to child mortality and encouraged increased accountability for children's health among the human rights community. She therefore welcomed the emphasis on integrating human rights in the draft action plan and favoured the adoption of the draft resolution.

Mrs SHIPTON-YATES (United Kingdom of Great Britain and Northern Ireland) welcomed the progress that had been made towards Millennium Development Goal 4, but warned that considerable further efforts were needed if the targets were to be met by 2015. She fully supported the accelerated response to neonatal health set out in the draft action plan. The United Kingdom wished to cosponsor the draft resolution.

Ms NISHIMURA (Japan) said that her country had provided various forms of support for maternal and child health, including technical cooperation, and yet improvement in the neonatal mortality rate had been relatively slow as compared with the under-five mortality rate. Concerned by the rising proportion of neonatal mortality, Japan therefore supported the action plan. Nevertheless, without adequate precautions in health interventions, disparities could easily arise between populations where health care services were readily available and those where they were not. Moreover, to achieve

maximum efficiency of financial and human resources in the implementation of the action plan, coordination among all stakeholders and related programmes was vital.

Mr BERTONI (Italy) agreed with the objectives and actions proposed in the action plan, which were in line with Italy's policies regarding maternal and child health. He appreciated the comprehensive and integrated approach proposed with a focus on education, the community, empowerment, adolescents, the need to recognize early signals, health surveillance and data collection. The 2020–2025 targets were challenging but vital for lowering neonatal mortality. Italy had reached some of the objectives and was working on others, such as postpartum home visits. Italy wished to cosponsor the draft resolution.

Dr LAHLOU (Morocco) commended the participatory approach used in drafting the draft action plan and affirmed Morocco's commitment to its international human rights obligations, especially those relating to children, and to Millennium Development Goals 4 and 5. Important successes achieved thanks to the national plans developed accordingly in the past decade included a reduction in maternal, child and indeed neonatal mortality. A new action plan for the period 2012–2016 set targets for further reductions, identifying measures to be applied throughout pregnancy, birth, breastfeeding and early childhood. In addition to prevention and awareness, those measures were intended to: strengthen and improve the quality of services; deliver those services free of charge; enhance professional skills; develop primary health care institutions; regulate treatments; and promote better health information management, programme leadership and mobile health coverage. The aim was to fulfil the responsibility of guaranteeing fair access to services and realizing the right to health enshrined in the Constitution. The national action plan was largely consistent with the draft action plan, which Morocco consequently supported and would endeavour to tailor to its own particular characteristics and resources with a view to contributing to achievement of the global objectives.

Ms GOMES (Brazil) pointed out that neonatal mortality had decreased slowly in the previous few decades but that progress should be possible thanks to new interventions and service channels offering effective ways of improving health care coverage and quality. Brazil had succeeded in reducing child mortality by 41.5%, and in achieving Millennium Development Goal 4, through primary health care, a family health strategy and a national breastfeeding policy. The country also had the largest human milk bank network in the world and worked with several countries to share its milk bank technology. She supported the draft resolution.

Ms FERENIUS (Sweden) said that the draft action plan would make an important contribution to reducing newborn mortality as it would bring together all relevant actors around a common set of targets. She appreciated that the action plan had been developed as part of an inclusive and transparent process, ensuring good ownership and coherence. She endorsed the action plan as presented and urged other Member States to do so too. Her country wished to cosponsor the draft resolution.

Dr SLAMET (Indonesia) said that the neonatal mortality rate had remained stable in Indonesia over the previous 10 years. He supported the targets set for ending preventable newborn deaths by 2035, noting that Indonesia had set its own targets guided by the draft global action plan. He also recommended: adding a reference to a maternal mortality rate target by 2030; suggesting methods for measuring that rate; and ensuring that the global newborn action plan and maternal action plans were well integrated to ensure a continuum of care.

Mrs KARAVA (Greece), speaking on behalf of the European Union and its Member States, supported the adoption of the Every Newborn action plan in its current form and stated that the European Union was not in favour of reopening debate on its content at such a late stage.

Ms Yu-Hsuan LIN (Chinese Taipei) advocated a continuous and holistic approach to newborn health from the reproductive period through to childhood. Chinese Taipei was planning to extend health care services to include “pre-pregnancy” by providing newly-weds with health counselling and manuals on pregnancy. Mechanisms should be introduced for reporting underweight and premature babies so that follow-up care could be provided for high-risk cases. With regard to congenital anomalies and diseases related to premature birth, Chinese Taipei had increased subsidies for prenatal genetic diagnosis, improved prenatal examinations, and offered subsidized screening for group B streptococcal infections in pregnancy. Births, deaths and pregnancies were monitored through various birth-reporting systems. As funding was imperative for promoting better care for newborns, she proposed that WHO recommend effective strategies for gaining access to funds.

Dr DE BERNIS (United Nations Population Fund) said that, in 2013, more than 200 000 women had died from maternal complications, some 2.9 million newborns had died and 2.6 million stillbirths had occurred. The situation was therefore still unacceptable because the vast majority of those deaths had been preventable and were the result of: the denial of access to high-quality, comprehensive and integrated sexual and reproductive health services for women and adolescents; the lack of protection of women and girls’ rights, including their reproductive rights; gender inequality; and poverty. Family planning services could prevent 30% to 40% of maternal deaths and avoid unnecessary stillbirths and newborn mortality and morbidity. He commended the work of WHO, UNICEF and other partners in the H4+ joint effort to give newborn health the priority it deserved within the continuum of care, on the basis of new data and evidence. The newborn health draft action plan recommended a focus on the time of birth as the most important factor for both the woman and the newborn baby. Efforts made over the previous decades to build and strengthen efficient integrated sexual and reproductive health services had to be accelerated through political will and increased financial resources. No post-2015 targets had been set for ending preventable maternal, neonatal and child mortality, even though UNFPA appreciated the recommendation to include the maternal mortality target for 2030 in the Every Newborn action plan.

A key component of high-quality and respectful sexual and reproductive health services was a competent and well-equipped health professional. In cooperation with WHO and the International Confederation of Midwives, UNFPA had recently supported 73 low- and middle-income countries to assess their midwifery workforce, which would be the theme of the upcoming State of the World’s Midwifery 2014 report entitled “A woman’s right to health”. Well-trained midwives could deliver nearly 90% of women’s needs for the sexual, reproductive, maternal and neonatal health interventions recommended by WHO, and yet some 50% of women gave birth without a midwife or other skilled health worker. Each maternal and neonatal death should be investigated in order to avoid a recurrence at the community and health facility levels. Ministers should assess progress and challenges through regular reports and genuine figures on maternal and neonatal deaths.

Dr DICKSON (United Nations Children’s Fund) said that UNICEF, as a co-chair of the Every Newborn effort, welcomed the fact that the draft plan had received so much attention and support. The approval was all the more gratifying since that year marked the 25th anniversary of the United Nations Committee on the Rights of the Child and the action plan put forward clear strategies and actions to ensure the rights of all children were met. UNICEF would continue to support countries in implementing the recommendations outlined in the action plan, including quality care for every mother and newborn, in order to end all preventable child deaths.

Ms BARCLAY (International Planned Parenthood Federation), speaking at the invitation of the CHAIRMAN, said that at least 222 million women worldwide were unable to access the family planning services they needed. Spacing births enabled women to bear children in their healthiest years, reduced the risk of maternal mortality and could therefore save the lives of more than one million infants and children annually. Family planning was also a cost-effective health investment, as US\$ 31 were saved on additional public and health expenditure for every US\$ 1 invested. She

welcomed the inclusion of rights-based family planning in the report, but was not comfortable with any mention of “pre-pregnancy”, as it was not a medical term and did not reflect the full range of women’s health concerns over their reproductive lives.

Ms DURLING (World Vision International), speaking at the invitation of the CHAIRMAN, urged Member States to endorse the newborn health draft action plan and translate pledges into action at national and local levels. To reach the target by 2035, the focus must be on equity, and mothers and babies in fragile, conflict-affected and emergency settings must have access to quality health services, and particularly to life-saving commodities and skilled birth attendants. To count every newborn and child, including those who were currently unseen, invisible and unregistered, civil registration and statistics systems should be expanded towards universal coverage, with the focus on vulnerable children and women. If adequately supported, families and communities themselves could play a vital role in their own health by creating demand, improving home practices, and monitoring and holding duty bearers to account for the delivery of quality services.

Ms RIGGS-PERLA (The Save the Children Fund), speaking at the invitation of the CHAIRMAN, said that newborn mortality was a key indicator of the strength of a health system and its ability to provide essential services. She urged delegates to adopt the action plan and implement its key actions so as to enhance universal health coverage and the right to health. Universal health coverage was sometimes characterized as vague and utopian, and yet the draft action plan had set out specific targets. In the future, maternal mortality targets should be added in order to improve the convergence between maternal and newborn health. She called on governments to set as a top priority the ending of preventable newborn deaths and stillbirths; to foster universal coverage of high-quality care; to ensure that by 2025 every birth was attended by an appropriately skilled health worker; to increase expenditure on health to at least the WHO minimum of US\$ 60 per capita; and to remove financial barriers for all maternal, newborn and child health services, including emergency obstetric care. The action plan should act as a spur to transform health systems.

Ms CHANETSA (International Baby Food Action Network), speaking at the invitation of the CHAIRMAN, praised the reference to the duties of private sector enterprises to promote community and workplace support for mothers in relation to pregnancy and breastfeeding and to ensure that marketing and promotional practices fully conformed to the provisions of the International Code of Marketing of Breast-Milk Substitutes and Health Assembly resolutions. For the sake of consistency in the document, those obligations should be included in Annex 3, “Actions by constituency”. Governments should ratify the ILO Maternity Protection Convention and enforce legislation on the International Code as a way of protecting the rights of women and newborns, especially those in poverty. Further, the rights of women and newborns should be reflected as additional indicators in Annex 2. As early initiation of breastfeeding fundamentally reduced neonatal deaths, the recognition of Baby-Friendly Hospital Initiatives as criteria for quality maternal and newborn care was welcome, and early initiation of breastfeeding should be included as a core indicator for the coverage of care. She expressed concern that no mechanism had been included in the action plan for the reporting of achievements towards the 2020 and 2025 targets to the Health Assembly.

Ms TEN HOOPE BENDER (International Confederation of Midwives), speaking at the invitation of the CHAIRMAN, said that midwives were a crucial element for achieving the goals and targets of maternal and newborn action plans, although they would need to be educated to international standards; to be able to work in safe and enabling working environments in order to work closely with women and families; and to have direct access to next-level care. Comprehensive regulations enabled midwives to work to the full scope of their practice. Investing in midwives paid off as it saved lives, precluded the need for further interventions and brought the health system closer to communities. Countries and development partners should tailor in-service training to fewer professional groups, reduce costs and improve the efficiency and quality of care.

Ms STARRS (Global Health Council, Inc.), speaking at the invitation of the CHAIRMAN, fully supported the Every Newborn draft action plan. The slower pace of the decline in newborn mortality required specific focus within the reproductive, maternal, newborn and child health continuum to ensure that interventions for newborns were incorporated into budgets, training curricula and commodity systems. It was also crucial to recognize the integral links between maternal and newborn health, as newborn mortality could not be reduced without improving maternal health, and maternal health could not be protected without access to reproductive health services. Member States should support the inclusion in the action plan of a target of 70/100 000 live births (the average global maternal mortality ratio) for ending preventable maternal deaths by 2030, as it would clearly demonstrate that maternal and newborn health were interlinked. She also recommended that the action plan retain its vision set out in paragraph 9 of the report, with particular emphasis on the phrase “every pregnancy is wanted”. Some 220 million women claimed to want to postpone birth for at least two years or stop childbearing but were not using effective contraception, leading to unplanned births, abortions, stillbirths, newborn deaths, maternal deaths and child deaths.

Dr BUSTREO (Assistant Director-General) said that the support for the newborn health draft action plan demonstrated the centrality of newborn health within the continuum of care for reproductive, maternal, newborn and child health and the priority accorded to it within Member States’ national plans. That support further suggested that the goals in the report should remain central to the post-2015 development agenda. Drawing attention to the participatory process for elaborating the action plan, she highlighted the fact that Member States had been able to provide their input at various stages and that platforms such as the Every Woman, Every Child initiative and the Partnership for Maternal, Newborn and Child Health had helped to ensure the action plan’s coherence within the United Nations structure. She assured Member States that the development of the action plan was consistent with the “right to health” approach and that WHO would continue to work with the United Nations Human Rights Council to develop a further resolution on child mortality. She would appreciate receiving information from delegates who had mentioned the development of their own national plans. As requested by some Member States, the Secretariat had taken note of all the comments and proposed amendments, and would try to accelerate the development of the implementation plan and the framework for monitoring and accountability, for which additional resources would be needed.

The CHAIRMAN said that a revised version of the draft resolution, reflecting the amendments proposed, would be circulated on the following day.

Dr RUSIBAMAYILA (United Republic of Tanzania) requested that the amended version of the draft action plan should also be circulated.

It was so agreed.

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

The meeting rose at 21:10.

ELEVENTH MEETING

Saturday, 24 May 2014, at 09:45

Chairman: Professor PE THET KHIN (Myanmar)

1. FIFTH REPORT OF COMMITTEE A (Document A67/70)

Dr MBUGUA (Kenya), Rapporteur, read out the draft fifth report of Committee A.

The report was adopted.¹

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

Multisectoral action for a life course approach to healthy ageing: Item 14.4 of the Agenda (Document A67/23)

Professor HALTON (Australia) welcomed the report, particularly its focus on long-term care. Ageing was accompanied by an increase in the burden of disease, especially noncommunicable diseases, and she welcomed the proposal for a comprehensive global strategy and plan of action. She therefore proposed a draft decision which read as follows:

Recognizing that the proportion of older people in the population is increasing in almost every country, and the growing challenges for health systems associated with population ageing, the Assembly decided to request the Director-General to develop, in consultation with Member States and other stakeholders, and coordinated with regional offices, and within existing resources, a comprehensive global strategy and plan of action on ageing and health for consideration by the Executive Board in January 2016 and the World Health Assembly in May 2016.

Mr SEY (Gambia), speaking on behalf of the Member States of the African Region, said that the increase in demand for various health services for older persons rendered ageing a major challenge for the 21st century which should be met through policies and cooperation with older persons' associations, nongovernmental organizations, research institutions and the private sector. The Madrid International Plan of Action on Ageing and the African Union Policy Framework and Plan of Action on Ageing would continue to guide Member States in the Region in drafting appropriate legislation. The Secretariat should continue to support Member States in developing a continuum of health care, from primary to palliative care, and in building capacity to meet the needs of older people.

Mr JONES (Canada) recognized that promoting healthy ageing required a multisectoral approach. Given the current demographic shifts and the resulting policy implications, he supported the proposal for a global strategy and action plan on ageing and the proposed draft decision.

¹ See page 348.

Dr LAHTINEN (Finland), speaking on behalf of the Member States of the European Region, supported the proposal for the submission of a draft global strategy and action plan on ageing to the Sixty-ninth World Health Assembly. In 2012, the Regional Committee for Europe had adopted resolution EUR/RC62/R6, urging Member States to make use of the strategy and action plan for healthy ageing in Europe 2012–2020, which took the perspective of the life course, advocated long-term care systems fit for ageing populations and research, and focused in particular on dementia, recommending investment in care for patients with that condition. The foundations of health should still be promoted in old age. Efforts across all sectors were needed, including in the development of supportive environments. Aspects of other WHO strategies, such as those on mental health and noncommunicable diseases, needed to be integrated into the strategy on ageing.

Dr AL HAJERI (Bahrain) said that it was essential to develop health systems and step up efforts to ensure that older persons enjoyed good health. Bahrain guaranteed the health, social and economic rights of older persons through a national strategy for their care. It was among the first Arab States to have established a national committee for older persons, which had drawn up a national implementing plan. It aimed to promote health and life quality and deliver health services in all areas of the country, and the health ministry had established a mobile unit providing health and social services to older persons at home. Policies were in place to protect older persons from ill health, with measures that included development of primary health care services, provision of age-friendly environments and transport, integrated social care and support of nongovernmental organizations involved in caring for older persons. She supported the report's recommendations and the development of a global strategy that should include performance indicators for measuring progress at the country level.

Dr AL-TAAE (Iraq) noted that measures to guarantee health care for an ageing population covered primary health care services, including: prevention; psychosocial support through health visitors; provision of family care; adaptation health facilities for older persons; integrating geriatric services into hospitals, including rehabilitation facilities; advocacy and communication with civil society; capacity-building for health professionals; and improving specialized geriatric health care. A national committee had been established to draft policies for healthy ageing with a multisectoral approach.

Mr FERDINAN TARIGAN (Indonesia) said that his Government's Ministry of Health was collaborating with other ministries and agencies on a comprehensive national five-year work plan based on the life course approach to healthy ageing. National and provincial committees had been set up and research was being conducted in national education institutions. Following the Yogyakarta Declaration on Ageing and Health, the health ministry was updating the standards of health care for older persons and was planning a task force for the application of the life course approach in health care. He requested further technical support from the Secretariat in ensuring healthy ageing.

Dr FEISUL IDZWAN MUSTAPHA (Malaysia) acknowledged that health systems were inadequately designed to meet the needs of an ageing population. He welcomed new social models with a life course approach, strengthening intergenerational links and requiring multisectoral action. His country would continue to develop an ageing-sensitive agenda, raise awareness in society of the ageing population, and provide incentives for family care of older persons. He supported the draft decision.

Ms KRISTENSEN (Denmark), speaking on behalf of the five Nordic countries, Denmark, Finland, Iceland, Norway and Sweden, and the three Baltic countries, Estonia, Latvia and Lithuania, welcomed the priority given to the topic. The life expectancy of older persons was likely to continue to increase, bringing them life options that had not been previously envisaged; they should thus be seen as a valuable resource in society and in the labour market besides a challenge to health services. WHO's guidance was needed, but development of a global strategy would need a budget allocation. A

strategy and action plan should include multisectoral contributions and action, engaging both public and private sectors. The objectives should be to optimize the health of older persons and to empower them; to promote a health through the life course approach; and prevention with a focus on noncommunicable diseases and mental health. A global report on ageing and health issued in 2015 would serve as a solid platform for the development of a constructive strategy and plan.

Mrs PENIĆ IVANKO (Croatia) supported the draft decision. Healthy ageing required the development of evidence-based non-institutional care and other community-based activities. She endorsed the recommendations in the report.

Mr YAPO (Côte d'Ivoire) said that his country had taken institutional, financial and administrative measures to cope with an ageing population. Many challenges remained at national level, including establishing specialized geriatric services, integrating palliative care into the general health system, and assessing the impact of an older population on the health system. Commending WHO's initiatives on healthy ageing, he said that his country would take ageing into account in its next action plan on noncommunicable diseases.

Mr DEANE (Barbados) welcomed the proposal for a report on healthy ageing and endorsed the draft decision for the preparation of a comprehensive strategy and action plan and the call for evidence-based best practices to design policies that would ensure the implementation of a life course approach to healthy ageing. The diverse demographic patterns of different countries could provide the opportunity for Member States to share lessons learnt. His country was committed to ensuring healthy ageing, in line with the effectiveness and value of the life course approach. An approved Government white paper on ageing set out the roles of the various actors involved and the legislative changes needed for the implementation of strategies. Barbados had developed programmes to provide a wide range of social support for the elderly, and nongovernmental organizations played a crucial role in that regard. Their contribution, some of it reimbursed, to the well-being of older people could well be expanded, if supported by relevant research.

Dr ASUNCION (Philippines) observed that the older population suffered from the double burden of degenerative and infectious diseases and that noncommunicable diseases were currently the leading cause of their mortality. Her country had adopted various measures, including strengthening policies to promote healthy ageing, and had drafted guidelines on older persons' health, which aimed, inter alia, to enhance delivery of geriatric care and secure equitable financing for health care. She appreciated WHO's efforts to strengthen the prevention and control of noncommunicable diseases in older persons and keenly awaited the results of the studies into evidence-based strategies. She fully supported the draft decision.

Ms SINGH (South Africa) noted that older persons' various health problems included communicable and noncommunicable diseases, mental health conditions, and disabilities. Many older people in her country had borne the brunt of the apartheid system which had deprived them of their rights, resulting in a cohort that was particularly vulnerable to poverty and poor health. Healthy ageing was complex, depended on more than responsive health systems and demanded intersectoral collaboration with participation of civil society and older persons themselves. She welcomed the proposal for a global report on ageing and health and supported the draft decision.

Mr KOLKER (United States of America) considered that the continuum of care should include disease self-management and cover both physical and mental health, given that, with the appropriate tools, older people could better manage their own well-being. Long-term care systems should provide older persons with the possibility to choose their care, including attendance in their own home, where possible. He welcomed the call to fill knowledge gaps in the field of ageing, where more disaggregated data were needed, notably in the area of ill-treatment of older persons. Disability also

needed to be examined in the context of ageing, with functional status being recognized as a key component of good health. A report on ageing and health would be welcome and it might constitute a framework within which to develop the proposed comprehensive global strategy and plan of action.

Dr SHIMIZU (Japan) supported the draft decision. His country was tackling the issues raised by the growing older population, such efforts being aimed at providing, *inter alia*, social welfare and other lifestyle support services. With an expanding older population and a shrinking workforce, maintaining social welfare funding was a major challenge. A working group had been set up to exchange knowledge with other countries on the issues. Ensuring health coverage for older people, at reasonable out-of-pocket cost to them, was imperative. WHO should consider the global situation of older persons and gather evidence on sustainable funding systems with a focus on population ageing.

Dr WICKRAMASINGHE (Sri Lanka) said that the increase in the number of older people (currently 10% of the population but expected to rise to 22% by 2030), accompanied by a rise in noncommunicable diseases and a need for longer-term care, presented a challenge to health care coverage. Given that more women were entering the work force, provision of care to the elderly in the home was also more complex. It was important to define the best steps that countries at different levels of development could take to provide a continuum of care. Measures should also be envisaged to reintegrate older persons into the labour market, which would improve their social engagement and benefit the community.

Dr ZHOU Jun (China) supported the recommendations that health systems should give priority to integrated care and the promotion of older persons' health. A collaborative research project conducted between his country and WHO would help China to select appropriate policy options for healthy ageing, and it was to be hoped that other Member States, particularly developing countries, would also benefit from the results. He called on WHO to take account of the situation of developing countries and least-developed countries when preparing the global strategy and to focus on the areas of nutrition, disease, disability and home care for the older population.

Mr HO (Singapore) commented that his country had one of the fastest ageing populations and one of the highest life expectancies in the world. The health care system was undergoing major reforms, enhancing universal health coverage and improving infrastructure and services to cater for increasing demand and rising expectations. Political will and commitment of resources were important, but in addition WHO should continue to provide leadership and knowledge in order to assist countries in their decision-making and actions. Each country's circumstances were unique, but a global strategy and plan of action offering global best practices would be beneficial. He supported the draft decision.

Mr CHUAH (New Zealand), supporting the draft decision, requested the Director-General to ensure that the comprehensive global strategy and plan of action on ageing and health were linked to and aligned with WHO's disability initiatives and the global action plan for the prevention and control of noncommunicable diseases 2013–2020.

Dr GNASSINGBÉ (Togo) said that population ageing posed several major challenges, including demands on the health care system, long-term care and pensions. Most health systems were ill-equipped to deal with the needs of an ageing population and lacked infrastructure and qualified staff. His country had adopted a policy for the protection of older persons but many challenges remained, including raising awareness in society and promoting specialized health care for older persons. Good data were essential for the preparation of the global report on ageing and health.

Dr SEIXAS DOS SANTOS (Timor-Leste) said that communicable diseases were the leading cause of mortality among older people in his country (who made up about 8% of the population) but

the incidence of noncommunicable diseases in the older population was also on the rise. With WHO's support, his country had implemented a community-based care programme for older persons, which aimed to strengthen primary health care. In addition, a national action plan concerning older persons had been adopted. He thanked the WHO Country Office for its work in the area and requested ongoing support from the Secretariat.

Dr BENJAWAN TAWATSUPA (Thailand), noting that Thailand was an ageing society with the elderly population amounting to 15% of the total in 2014, appreciated the progress made on the healthy ageing agenda. Multisectoral action was urgently required with a life course approach to healthy ageing that took the form of public health interventions and included a continuum of care to the end of life and dignity for the dying. Thailand had adopted a national health promotion strategy that encompassed "good deaths" but fell short with regard to health security, sustainable funding and the provision of acute and long-term care. The strategy also faced gaps in terms of evidence-based strategies, innovation development, and workforce capacity-building and development, in particular for those caring for the elderly and primary health care workers. She supported the draft decision.

Dr TRAN THI GIANG HUONG (Viet Nam) said that ageing was accorded priority in governmental policy in Viet Nam, where people over the age of 65 years accounted for more than 17% of the population in 2011. In order to strengthen and guide Member States' actions, the Secretariat was requested to consider developing a global strategy and action plan on ageing and health; establish and facilitate international cooperation and technical support for models of elderly care that could be applied in developing countries; and formulate strategies and mechanisms for the financing of longer-term care, it being crucial to obtain evidence on sustainable financing models that incorporated multisectoral collaboration and a community-based approach but did not expose families with elderly members to financial hardship.

Mr KLEIMAN (Brazil) said that the impact of population ageing would be immediate. The process entailed challenges but should also be seen as an opportunity to improve national health systems and exploit elderly people's knowledge. Because ageing populations led to increased health system costs, the emphasis had to be on prevention and health promotion policies. Population ageing should be reflected in proposals for the post-2015 development agenda. Gender aspects needed to be prioritized, as women lived longest and cared for family members in most cases. It was crucial for countries to seek cooperation with Member States that had public ageing policies and had experienced successful evidence-based outcomes. He supported the draft decision.

Ms JIMÉNEZ VALDEZ (Mexico), recognizing that many of the causes of functional decline originated early in life, said that it was important to care for the individual's basic needs and to foster a holistic and multisectoral culture of healthy ageing. Emphasizing disease prevention, she supported the preparation of a global strategy on ageing and health.

Ms ADAM (Maldives) warned that the opportunity costs of not dealing strategically with ageing would adversely affect society and the economy as well as health. The challenges it posed could be met by promoting healthy lifestyles, and therefore interventions against noncommunicable diseases should start in childhood. In different capacities, both formally and informally, older people made important contributions to society and their wisdom was a vital resource. Maldives had developed a national policy and strategy for active and healthy ageing and for elderly care. She acknowledged the Regional Strategy for Healthy Ageing. A comprehensive approach to ageing should be cross-sectoral and multifaceted, and include issues such as disability and mental illness.

Ms RIOS (Argentina) welcomed the report and supported the draft decision. As health and disease in old age were determined by factors throughout the life course, health systems needed to take

that approach. In addition, health had to be promoted through a multisectoral approach to its social determinants and through healthy lifestyles.

Argentina had adopted such an approach in its national programme for active and healthy ageing, which promoted the health, well-being and rights of the elderly in an integrated manner and focused on primary health care adapted to older people. The programme comprised health promotion and disease prevention activities for people of all ages, offering long-term care for frail or dependent adults, and training and capacity-building of health personnel in active and healthy ageing. A national intersectoral advisory commission had been created to coordinate activities. A national report on the health situation of the elderly was being written in order to enhance knowledge and as input for WHO's proposed global report on health and ageing in 2015.

Ms Yu-Hsuan LIN (Chinese Taipei) described the measures taken by Chinese Taipei in application of the life course approach to healthy ageing: the provision of health promotion services ranging from prenatal examinations to adult preventive health care services, fully subsidized programmes for screening of four major cancers and the promotion of age-friendly cities. She endorsed the Secretariat's focus on making the WHO Global Network of Age-friendly Cities and Communities a platform for experience-sharing, and, echoing its call for a life course approach to healthy ageing, recommended the establishment of a framework that would allow health care institutions to provide holistic, age-friendly health care. In application of the Age-friendly Principles outlined in the WHO publication *Towards Age-Friendly Primary Health Care*, Chinese Taipei had developed a certification programme with a self-assessment manual for age-friendly health care institutions and was working with the International Network of Health Promoting Hospitals and Health Services to promote that programme globally.

Dr BEARD (Ageing and Life Course) affirmed that population ageing was a complex issue entailing an urgent need for a comprehensive public health response. Delegates' statements had highlighted various requirements, including the need to develop an integrated continuum of care, provide support to countries at all levels of economic development, consider health impacts throughout the life course, create age-friendly health facilities, improve gender sensitivity, introduce new systems of long-term care and innovation, and apply a supportive environment and multisectoral approach. Work force capacity had to be strengthened and new life options considered; strategies had to be evidence-based and research in the field bolstered. The Secretariat would facilitate a comprehensive consultative process leading to the development of a global strategy and action plan that reflected those key issues and was integrated with other strategies, such as those pertaining to noncommunicable diseases and mental health. That process would be conducted in close coordination, as suggested, with the proposed work on the WHO global report on health and ageing.

Dr ARMSTRONG (Secretary) read out the draft decision proposed by the delegate of Australia on multisectoral action for a life course approach to healthy ageing.

The CHAIRMAN took it that the Committee was prepared to approve the draft decision.

The draft decision was approved.¹

¹ Transmitted to the Health Assembly in the Committee's sixth report and adopted as decision WHA67(13).

Newborn health: draft action plan: Item 14.2 of the Agenda (Documents A67/21 and A67/21 Corr.1)
(continued from the tenth meeting, section 2)

The CHAIRMAN asked whether the Committee was prepared to approve the draft resolution, as amended, which now read:

The Sixty-seventh World Health Assembly,

PP1 Having considered the reports on the newborn health: draft action plan,¹ monitoring the achievement of the health-related Millennium Development Goals² and health in the post-2015 development agenda;³

PP2 Recalling resolution WHA58.31 on working towards universal coverage of maternal, newborn and child health intervention, resolution WHA63.15 on monitoring of the achievement of the health-related Millennium Development Goals, resolution WHA64.9 on sustainable health financing structures and universal coverage, resolution WHA64.13 on working towards the reduction of perinatal and neonatal mortality, and resolution WHA65.7 on implementation of the recommendations of the Commission on Information and Accountability for Women's and Children's Health;

PP3 Acknowledging the pledges and commitments made by a large number of Member States and partners to the United Nations Secretary-General's Global Strategy for Women's and Children's Health, which aims to save 16 million lives by 2015;

PP4 Recognizing that millions of children and women die needlessly each year during and around the time of childbirth, and that effective interventions are available and feasible for implementation at scale to end preventable maternal, newborn and child deaths;

PP5 Recognizing that ending preventable maternal mortality is within reach and that its achievement will accelerate the achievement of the newborn mortality target;[Cameroon]

PP56 Concerned that there has been insufficient and uneven progress towards achieving Millennium Development Goal 5 (Improve maternal health);

PP7 Also concerned and [Cameroon] that, although progress has been made towards achieving Millennium Development Goal 4 (Reduce child mortality) in terms of the overall reduction of child mortality, the reduction of perinatal and neonatal mortality has stagnated and the proportion of neonatal deaths among all child deaths is increasing;

PP68 Recognizing the need to intensify action urgently in order to end preventable neonatal deaths and preventable stillbirths, especially by improving access to and quality of health care for women and newborns, **[particularly of those at risk], [Cameroon] [especially for high-risk groups] and [Thailand]** including the prevention of the transmission of HIV from mother to child, within the continuum of care for reproductive, maternal, newborn and child health,

1. ENDORSES the newborn health: action plan⁴, **with amendments as suggested at the Sixty-seventh World Health Assembly;**

¹ Document A67/21.

² Document A67/19.

³ Document A67/20.

⁴ Contained in document A67/21.

2. URGES Member States¹ to put into practice the newborn health: action plan, through steps that include:
 - (1) reviewing, revising and strengthening their national strategies, policies, plans and guidelines for reproductive, maternal, newborn and child health in line with the goal, targets and indicators defined in the newborn health: action plan, **[and strongly committing to their implementation] [Cameroon] [with particular focus on high-risk groups]; [Thailand]**
 - (2) committing themselves, **according to their capacities, [Oman]** to allocating adequate human and financial resources to improve the **access to and the [Thailand]** quality of care, **particularly [Cameroon] but not limited to [Tanzania] care for the mother and the newborn child during labour, around birth and the first week, [Cameroon]** and achieve the national newborn health targets in line with the global action plan;
 - (3) strengthening **national health management [Thailand]** information systems so as better to monitor quality of care and to track progress towards ending preventable maternal and neonatal deaths and stillbirths;
 - (4) ~~reporting every second year to the Health Assembly~~ **sharing information [Australia]** on lessons learnt, progress made, remaining challenges and updated actions to reach the national newborn and maternal health targets;

3. REQUESTS the Director-General:
 - (1) to foster alignment and coordination of all stakeholders ~~in order to mobilize more financial resources and to~~ **[Cameroon]** support the implementation of the newborn health: action plan;
 - (2) to identify **and mobilize, within approved current and subsequent, programme budgets, more [Cameroon]** human and financial resources for the provision of technical support to Member States in implementing the newborn health component of national plans and monitoring their impact;
 - (2bis) **to prioritize the finalization of the more detailed monitoring plan with coverage and outcome metrics to track progress of the Newborn Action Plan; [Norway]**
 - (3) to monitor progress and report ~~every second year, periodically~~ **[Australia]** until 2030, to the Health Assembly on progress towards achievement of the global goal and targets using the proposed monitoring framework to guide discussions and future actions.

Dr TAKIAN (Islamic Republic of Iran), speaking on behalf of the Member States of the Eastern Mediterranean Region, proposed the following amendments to the newborn health draft action plan. In paragraph 90, in the third sentence, the phrase “, in line with national policies and priorities, cultural norms and religious values, as well as social characteristics of Member States,” should be added between “Young people” and “should be able to”, and the words “freely and” deleted. The final two sentences should be deleted. In paragraph 83, in point (i) in the box on Key actions for strategic objective 3, the phrase “, and use of, modern contraceptive methods and give pregnant adolescents the full support they need” should be replaced with the words “reproductive health education”.

He entreated the Secretariat to find an efficient way to communicate with Member States in order to inform them in a timely fashion of last-minute changes in the programme of work of Committees A and B. Changes in timing and transfers of items between committees were understandable in a context of vibrant and serious discussions, but they sometimes prevented Member States from being present when they wanted to speak on a particular item, as had been the case for the current agenda item: the unexpected rescheduling of the discussion to the tenth meeting without prior

¹ And, where applicable, regional economic integration organizations.

notice had meant that Member States of the Region had not been able to propose amendments. He appreciated the current opportunity to do so.

Dr AL HAJERI (Bahrain) stated that the draft action plan constituted a response to the urgent need for intensified efforts to end preventable newborn deaths, was evidence-based and set out clear strategic goals.

Dr RUSIBAMAYILA (United Republic of Tanzania) supported adoption of the draft resolution as amended.

Mrs KARAVA (Greece), speaking on behalf of the European Union and its Member States, recognized that wide consultations had taken place over the previous 12 months and therefore wanted to adopt the draft action plan as it stood. Discussion of the action plan should not be reopened at such a late stage.

Dr CHIKAMATA (Zambia) welcomed the draft action plan's focus on improving the quality of newborn care. Maternal health and newborn health were linked; in line with the principle of survival convergence, any policy or programme on either maternal or newborn health should therefore include the other; policies, programme strategies and services should address the health needs of newborns and mothers in an integrated fashion. Moreover, countries clearly preferred that approach.

Zambia, for its part, had reduced maternal mortality by 51% between 1990 and 2013, and child mortality to 50 per 1000 live births in 2012, paying special attention to the integration of reproductive health services with those for HIV. A policy on integrated community case management of common diseases for women and children had been agreed and its implementation scaled up. Her Government was committed to dealing with maternal and newborn health issues together and to avoiding preventable deaths through integrated policies and services that were accessible and of good quality.

To end preventable newborn morbidity and mortality, mothers had to be healthy throughout the reproductive period. That could be achieved through integration with community programmes that included empowerment of women, women's literacy programmes and conditional cash transfers. He therefore supported the proposal to include agreed targets for ending preventable maternal deaths in the draft action plan.

Mrs TYSON (United Kingdom of Great Britain and Northern Ireland) expressed astonishment at the poor process that was permitting an expert text that had been the subject of long and detailed consultation with Member States over the previous 12 months to be reopened on the floor of the Health Assembly at such a late stage. There was no time for delay in putting into practice the draft action plan, which Member States needed, in the version in document A67/21 and as agreed by a wide variety of Member States. She suggested that the Rules of Procedure of the World Health Assembly provided that an agreed expert text could not be reopened. A draft resolution, on the other hand, could be prepared to note the comments made by many Member States on the agreed text.

Mr KOLKER (United States of America) recalled that his delegation had also proposed an amendment to the draft action plan, on maternal mortality; that amendment had been accepted by all. The important thing, however, was to agree on the plan; his country would therefore be willing to withdraw its proposed amendment to that end even though it had been agreed. Reopening the discussion with a series of controversial amendments would not advance the goal of newborn survival.

Dr AL-TAAE (Iraq) and Dr ALWADAANI (Kuwait) endorsed the amendments proposed by the delegate of the Islamic Republic of Iran.

Mr LINDGREN (Norway), supported by Mr BEDFORD (Australia), agreed that the draft action plan had been the subject of extensive consultations and that it should not be reopened for discussion by the Health Assembly.

Mr PARIRENYATWA (Zimbabwe) considered that the draft action plan was open to amendment and that all amendments should be considered by the Health Assembly, which was the highest governing body of WHO.

Ms PALMIER (Canada) urged adoption of the draft action plan, which was a technical document, and said that she trusted the Health Assembly to find a way to come to terms with the various amendments put forward. She asked the Secretariat to express its views on those amendments and whether they could be incorporated into the plan before it was launched.

The CHAIRMAN noted that there was disagreement about how to proceed and suggested that the two groups meet to find a way forward.

Ms FERENIUS (Sweden) strongly supported the draft action plan as it had been presented. However, in a spirit of compromise and given the lack of time, she proposed that paragraph 1 of the draft resolution be amended to read: “ENDORSES the newborn health: action plan¹ and notes the amendments as suggested at the Sixty-seventh World Health Assembly,”.

Ms LANTERI (Monaco) also supported the draft action plan as it had been presented. Having neither seen nor discussed any of the proposed amendments, she would find it difficult to agree even to the amendment proposed by Sweden to the draft resolution. Moreover, action plans submitted in meeting documents were not usually reopened for discussion, and she therefore objected to the reopening of the discussion on the content of the draft action plan. As part of its discussion of the draft resolution on health in the post-2015 development agenda, the Health Assembly was reviewing the Millennium Development Goals that had not been attained, including the target of newborn health; it was therefore crucial to adopt the draft action plan and implement it immediately.

The CHAIRMAN noted that various views had been expressed from the floor. In order to reach a solution acceptable to all, he proposed that those wishing to do so consolidate those views and come to a decision while the Committee continued with its agenda.

Mrs TYSON (United Kingdom of Great Britain and Northern Ireland) did not agree to that proposal. In her view, under the Rules of Procedure of the World Health Assembly, Member States should not and could not reopen an agreed expert text. She asked for a ruling on that point.

Professor HALTON (Australia), speaking from long experience of Health Assembly sessions, said that she shared the previous speaker's understanding of the situation. Furthermore, she and other delegates had not been able to review the proposed amendments to the draft action plan and therefore she did not agree with the amendment to the draft resolution proposed by Sweden. The Committee could either accept the draft action plan and the draft resolution, with the amendments to it previously proposed, or it would have to find another solution.

¹ Contained in document A67/21.

Dr TAKIAN (Islamic Republic of Iran) endorsed the amendment to the draft resolution proposed by the delegate of Sweden, which was a good compromise, especially as there was no time to convene an informal working group.

Ms VACA (Colombia) objected to the proposal to establish an informal working group. The draft action plan was well drafted and based on scientific evidence; it contained best practices and each of its recommendations provided a technical response to the high mortality rates of children and mothers in many regions. The responsible decision was to adopt the plan.

Dr LAHTINEN (Finland) supported the proposed amendments to the draft action plan, which it was important to adopt at the current Health Assembly in order to facilitate achievement of the relevant Millennium Development Goals. He expressed difficulty in agreeing to amendments that he had not seen, and therefore would not be in a position to accept the amendment to the draft resolution proposed by the delegate of Sweden.

Dr RUSIBAMAYILA (United Republic of Tanzania) emphasized that documents were submitted to the Health Assembly in order for Member States to reach consensus on them. She agreed with the delegate of Zimbabwe that amendments to the draft action plan should be permitted.

Mrs TYSON (United Kingdom of Great Britain and Northern Ireland), rising to a point of order, again asked for a ruling on whether it was possible to open an agreed expert text at the Health Assembly.

Mr BURCI (Legal Counsel), after clarifying that he would only give an opinion and that only the CHAIRMAN could make a ruling, said that, on the one hand, the Health Assembly was WHO's supreme decision-making body. The draft action plan had been submitted to the Health Assembly for adoption, and the Health Assembly therefore had the authority to amend it if it so wished. On the other hand, an action plan was not a resolution; it was the outcome of a long process that included several consultations with experts and comments from Member States. The Secretariat had followed a process for drawing up complex documents such as draft strategies and action plans, which did not have the same rationale as resolutions, that comprised consultation with experts at political level and with regional committees specifically because when the time came to adopt such documents, which reflected the views of all stakeholders, it was difficult to start negotiating individual paragraphs and words. In the case at hand, if the Member States did not agree to hold informal consultations, they might, as a last resort, have to defer consideration of the draft action plan to the Sixty-eighth World Health Assembly, in 2015, and pursue their consultations on it in the meantime.

Dr BUSTREO (Assistant Director-General) considered it a matter of urgency to adopt the draft action plan immediately, leaving one full year before the deadline for attaining the Millennium Development Goals. The action plan would provide the impetus for that achievement in the final year. She suggested that paragraph 1 of the draft resolution be amended to read: "ENDORSES the newborn health: action plan,¹ taking into consideration the amendments as suggested at the Sixty-seventh World Health Assembly". That amendment implied that the Secretariat would consider all the amendments suggested when producing the final version of the action plan and incorporate their sense without modifying the plan's essence. The results would be shared in one week's time.

Mr ŽEROVEC (Slovenia) wanted the draft action plan to be adopted unaltered immediately. He suggested that the draft resolution be amended to read: "ENDORSES the newborn health: action plan,¹ and notes the amendments as suggested at the Sixty-seventh World Health Assembly".

¹ Contained in document A67/21.

The CHAIRMAN asked whether the Member States agreed with the amendment to the draft resolution proposed by the Secretariat.

Mrs PENIĆ IVANKO (Croatia), Ms PALMIER (Canada) and Mr PARIRENYATWA (Zimbabwe) supported that amendment in a spirit of compromise and in view of the need to adopt the draft action plan immediately.

Mr BOISNEL (France) said that reopening discussion of a plan categorized as urgent by some 40 delegates the previous day would set a dangerous precedent for the life and governance of the Organization.

Ms ALARCÓN MAYORGA (Colombia), agreeing, said that no change should be made to the draft action plan.

Mr RIETVELD (Netherlands) agreed that the draft action plan had to be adopted immediately without reopening the discussion.

Professor HALTON (Australia) found it difficult to agree to the Secretariat's proposed amendment. She would strongly prefer paragraph 1 of the draft resolution to simply read: "ENDORSES the newborn health: action plan". If Member States wanted the Director-General to take into consideration their views as expressed at the Health Assembly, paragraph 3 could be amended with the addition of a subparagraph requesting the Director-General to take into consideration the issues raised at the Sixty-seventh World Health Assembly.

Mr MIČ (Czech Republic) said that the draft action plan should be adopted as a matter of urgency, without amendment. The Member States should respect the complex work done by experts to produce it. He supported the proposal made by the delegate of Australia.

Dr LAHTINEN (Finland) said that it was difficult for Member States to consider something they had not seen on paper. That being said, the delegate of Australia had made a helpful proposal that might provide a solution.

The DIRECTOR-GENERAL agreed that it was reasonable for the Member States to know what they were being asked to consider. By requesting the Director-General to take the issues raised at the Sixty-seventh World Health Assembly into consideration, the Member States would be asking her to be sensitive to the national context when helping them implement the action plan; the resulting country ownership of the plan would only help to improve newborn health. Moving the amendment from paragraph 1 to paragraph 3 made the Secretariat responsible for delivering what was important to each country. She considered the amendment proposed by the delegate of Australia a reasonable compromise and urged the Member States to agree to it.

Mr ELIAS (Ethiopia), Mr BERTONI (Italy), Mr GWIAZDA (Poland), Ms KENNY (Ireland), Mr VALADAS DA SILVA (Portugal), Ms LANTERI (Monaco), Dr MÉSZÁROS (Hungary), Mr KOLKER (United States of America), Ms ROOVÄLI (Estonia) and Dr THAKSAPHON THAMARANGSI (Thailand) supported the amendment to the draft resolution proposed by the delegate of Australia and endorsed by the Director-General.

Ms C. GONZÁLEZ (Uruguay) said that delegations should not be obliged to accept amendments they had not seen. However, given the urgency of the subject and the interest in the action plan, she agreed to the proposed amendment.

Dr ELOAKLEY (Libya) said that he had originally asked for the floor in order to endorse the amendments proposed by the delegate of the Islamic Republic of Iran, but agreed with the point of view expressed by the Director-General.

Dr RUSIBAMAYILA (United Republic of Tanzania) agreed that the draft action plan should be adopted by the Health Assembly. She preferred the Secretariat's original proposal, but would be ready to accept the Director-General's proposal if the words "where every pregnancy is wanted" were removed from paragraph 41 of the draft action plan.

Dr ASADI-LARI (Islamic Republic of Iran) said that he was fully aware of the importance of reducing maternal and newborn mortality rates. Although the plan had been long in the making, for the sake of comprehensiveness and taking into account the fact that resolutions had long shelf lives, he strongly recommended that the Secretariat take on board the amendments proposed as formulated.

Dr MWANSAMBO (Malawi) pointed out that 5000 newborn children had died since discussion of the agenda item had been opened the previous evening, underscoring the urgent need to adopt the draft action plan. He therefore agreed with the Secretariat's proposal.

Ms MARTHOLM FRIED (Sweden) said that, in a spirit of compromise, she supported the amendment proposed by the delegate of Australia and endorsed by the Director-General.

Mr BOISNEL (France) fully supported the spirit of the amendment proposed by the delegate of Australia and endorsed by the Director-General. He suggested that it be inserted as subparagraph 3(2ter) in the draft resolution and worded as follows: "to take into due consideration, as appropriate, the views expressed by the Sixty-seventh World Health Assembly;".

Mr KLEIMAN (Brazil), having consulted with several delegations, proposed that the words "with amendments as suggested at the Sixty-seventh World Health Assembly" be deleted from paragraph 1 of the draft resolution and that the following subparagraph be added to paragraph 3: "to take into due account the domestic context when supporting the implementation of the plan of action at the national level".

Ms BONNER (Germany) was also keen to see the draft action plan adopted and would have preferred for it to be unamended. In a spirit of compromise, she nevertheless agreed to the amendment to the draft resolution proposed by the delegate of Australia.

Dr ZAKARIA (Ghana) agreed with the Director-General's compromise position to endorse the draft action plan and to take into consideration the national context when addressing the issues being raised.

The DIRECTOR-GENERAL, taking into account the wording proposed by the delegates of Australia and Brazil, proposed that the following subparagraph be added to paragraph 3: "to take into due account the views expressed at the Sixty-seventh World Health Assembly as well as the domestic context when supporting the implementation of the plan of action at the national level".

Dr RUSIBAMAYILA (United Republic of Tanzania) pointed out that, if the Director-General's final proposal was inserted into paragraph 3 and paragraph 1 was limited to adoption of the draft action plan, then paragraph 2, which urged Member States to take certain steps, would not stipulate that they, too, should take into consideration the national context. She therefore suggested that the additional subparagraph be inserted into paragraphs 2 and 3.

The DIRECTOR-GENERAL replied that the additional subparagraph should be inserted in paragraph 3 because the Secretariat had to honour the country context, commitment and leadership. At country level, implementation was up to each Member State; she could not impose it. The Secretariat simply provided support.

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

The draft resolution, as amended, was approved by acclamation.¹

Public health impacts of exposure to mercury and mercury compounds: the role of WHO and ministries of public health in the implementation of the Minamata Convention: Item 14.5 of the Agenda (Documents A67/24 and EB134/2014/REC/1, resolution EB134.R5)

The CHAIRMAN drew attention to the draft resolution recommended by the Executive Board in resolution EB134.R5.

Ms C. GONZÁLEZ (Uruguay), recalling that Uruguay had chaired the negotiations on the Minamata Convention on Mercury, expressed satisfaction at the draft resolution. The Convention's effective implementation required an intersectoral approach, although the health sector had a major role to play in the control and prevention of exposure to mercury. Hospitals were among those chiefly responsible for mercury emissions into the atmosphere, especially as a result of the incineration of medical waste. WHO played a key role in that context. It provided information and facilitated the establishment and building of the capacities, as appropriate, of States and health authorities to discharge their obligations under the Convention. WHO's input during the Convention's negotiation was reflected in the fact that Article 16, on health aspects, referred to the role of WHO and encouraged the Parties to promote health care services for the prevention, treatment and care for populations affected by exposure to mercury or mercury compounds, and to establish and strengthen the institutional and health professional capacities for the prevention, diagnosis, treatment and monitoring of health risks related to the exposure to mercury and mercury compounds. In addition, the Convention contained numerous references to health matters, including the need to protect human health and the environment from anthropogenic emissions and releases of mercury and mercury compounds, and emphasized populations at risk, such as pregnant women, children and health workers in the sectors identified. The Convention also referred to the need for risk assessments at contaminated sites, information exchange, public education, research and monitoring, and set phase-out dates for certain products, including in the health sector.

Implementation of the Convention required coordinated work between relevant ministries at national level and collaboration and joint efforts by the various international organizations competent in the field, such as WHO, ILO and UNEP. She proposed that the following subparagraph be added to paragraph 3 of the draft resolution: "to report to the Seventieth World Health Assembly in 2017 on progress in the implementation of this resolution".

¹ Transmitted to the Health Assembly in the Committee's sixth report and adopted as resolution WHA67.10.

Dr NGUYEN THI LIEN HUONG (Viet Nam) stressed the importance of acceding to the Minamata Convention on Mercury. Viet Nam had been one of the first 92 countries to sign the Convention, and its Government was currently in the process of ratifying and implementing it. He therefore welcomed the report and supported approval of the draft resolution. Further scientific evidence was nevertheless needed on the risks of occupational exposure to mercury and mercury compounds, in particular for vulnerable groups such as health workers. In addition, the Secretariat should provide guidelines on evidence-based educational and preventive programmes aimed at mitigating the adverse effects of mercury and mercury compounds. With regard to the phasing out of mercury-added products by 2020, the health ministries should be the lead agencies for phasing out mercury-containing pesticides and biocides used for household and medical purposes.

Dr AL-TAAE (Iraq) said that the use of mercury and mercury compounds had to be more widely prohibited and replaced. Finding substitutes for mercury-containing preservatives would require more research. When mercury or mercury compounds had to be used, stringent measures must be applied in order to ensure that such use was not to the detriment of public health. WHO should discharge its role in application of the Minamata Convention on Mercury.

Dr KISAKA (Japan) said that Japan's adherence to the Minamata Convention on Mercury reflected its intention to prevent a repeat of the tragedy of Minamata disease, which had brought suffering to thousands of people in Japan since the 1950s. Japan offered to share its knowledge and experience of measures to cope with Minamata disease. WHO should continue to engage in dialogue with both the Intergovernmental Negotiating Committee and the Conference of the Parties about its activities and those of the Member States under the Convention. It should pursue activities on the health effects of chemical substances and efficiently discharge its role under the Convention.

Mr RATIGORN GUNTAPONG (Thailand) acknowledged the importance of dealing effectively with the potential health risks of chemicals and chemical waste, including mercury, in particular to vulnerable groups such as women and children, and therefore supported the draft resolution. However, he expressed two concerns. First, a comprehensive view was needed of the groups facing the highest risks from mercury and its compounds, therefore not only women and children, but also those who were at risk because of their occupation or from the environment, including health workers. Secondly, the health sector could not work alone. Ministries of the environment, labour, industry, finance, commerce and agriculture and other agencies must collaborate with the health sector on the health aspects of exposure to mercury and mercury compounds. Multisectoral cooperation needed to be strengthened to that end and a strategic plan developed for effective implementation.

Mrs ORTEGA CRESPO (Spain) expressed support for adoption of the draft resolution. The Minamata Convention on Mercury called for the preparation and implementation of health strategies and programmes to help to identify and protect people exposed to mercury, especially the most vulnerable. It also called for measures to ensure environmentally sound management of mercury and mercury wastes. The link established by the draft resolution between WHO and its Member States, on the one hand, and the Convention, on the other, would help to facilitate cooperation between the health sector and sectors such as agriculture, fisheries, the environment and labour. It would lead to more effective control and more efficient risk management by promoting the application of public health policies protecting the entire population, especially the most vulnerable sectors, and future generations. Spain was in the process of ratifying the Convention and she encouraged others to do so.

Dr MANAMOLELA (Lesotho) noted that human beings could be exposed to mercury when it was released into the environment or by other mechanisms, and that the health consequences were dire, including for health workers. Lesotho had yet to assess the sources and impact of mercury in the country, but was nevertheless preparing to sign and ratify the Minamata Convention on Mercury. To fulfil its role of protecting public health, Lesotho would require the Secretariat's guidance on the

development and adaptation of national guidelines in line with WHO's norms and standards and on strengthening the capacity of health workers to conduct the necessary assessments, monitor and manage the effects of exposure to mercury, and implement a programme to phase out the use of mercury in public and private health care facilities. A strong awareness programme would be needed to induce stakeholders to change practices, and advocacy would be needed to encourage policy- and decision-makers to amend the relevant national policies and legal framework. She supported the draft resolution.

Ms VACA (Colombia) applauded the historic adoption of the Minamata Convention on Mercury, which reflected the work of governments and others for reductions in the use of mercury so as to protect health and the environment. Mercury was widely used in Colombia in small-scale mining operations, which tended to operate in remote parts of the country and provided a subsistence livelihood for many people. It was therefore necessary to introduce methods of extraction that did not require mercury. Colombia believed in the importance of multilateral international instruments like the Convention and the draft resolution, which served to establish mechanisms of global coordination, alliances for joint work by States, and concrete action leading to reductions in the use of mercury. She urged the Member States to start the ratification process as soon as possible, so that the commitment shown by all concerned during the negotiations could be sustained by the Convention's speedy entry into force.

Dr LLACUNA (Philippines) said that, as a signatory, the Philippines was committed to implementing the Minamata Convention on Mercury to the fullest extent. It had established an interagency committee headed by the Department of Health. Administrative orders had been issued to regulate and limit the use of mercury in the country and to start the gradual phase-out of mercury-containing devices and equipment in all public and private health care facilities. The registration of mercury-containing health devices and equipment had been banned, and only health facilities that had switched to mercury-free alternatives were accredited to the Philippine health insurance. The interagency committee was currently conducting consultations on dental amalgams.

Artisanal small-scale gold mining was common in the Philippines, where it provided a subsistence livelihood to about 300 000 families in more than 40 provinces. The Department of Health, working in collaboration with UNIDO, other government agencies and nongovernmental organizations, was currently implementing a project to improve the health and environment of such communities by reducing mercury emissions and finding alternatives to mercury.

The private sector needed to participate and invest in order to rationalize the use of mercury and reduce exposure to it in the long term. Financial and technical support from the private sector and strong political leadership from the Government were decisive factors that would strengthen and sustain the Convention's implementation. He supported the draft resolution.

Mr CORRALES HIDALGO (Panama), noting that the Minamata Convention on Mercury was the first international environmental treaty to contain an article specifically on health, said that it established a precedent for placing human well-being at the centre of all initiatives. Panama had been an active participant since the proposal had first been mooted and welcomed the outcome. For the Convention to have an impact on the national management of chemical products and waste, the health and environment sectors of the States Parties would have to work together. Multisectoral cooperation would have to be reinforced.

The Convention would enter into force only once it had been ratified by 50 States. Panama had been one of the first signatories and had started the ratification process. It encouraged the health ministries of all WHO's Member States to push for their countries' ratification, so that the Convention could be fully applied. He supported the amendment proposed by the delegate of Uruguay.

Ms PENEVEYRE (Switzerland) said that the Minamata Convention on Mercury, which Switzerland had signed in October 2013, was indicative of the willingness of States to make common cause and find solutions to global problems. For the Convention to be effectively implemented, it was essential to use existing expertise, promote synergies and avoid duplication. WHO, its Member States and other organizations of the United Nations system, in particular the joint Secretariat of the Basel, Rotterdam and Stockholm Conventions on the international management of chemical products and dangerous waste, had to work for the rapid entry into force of the Convention and its effective and efficient coordinated implementation. The health and environment sectors of the signatory States would be called on to cooperate, as would WHO and UNEP. She called for adoption of the draft resolution as amended by the delegate of Uruguay.

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

The meeting rose at 12:25.

TWELFTH MEETING

Saturday, 24 May 2014, at 14:45

Chairman: Professor PE THET KHIN (Myanmar)

1. ORGANIZATION OF WORK

The CHAIRMAN announced that, following consultation between the President of the Health Assembly and the chairmen of Committees A and B, item 16.5 (Antimicrobial drug resistance) would be transferred to Committee B.

It was so agreed.

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

Public health impacts of exposure to mercury and mercury compounds: the role of WHO and ministries of public health in the implementation of the Minamata Convention: Item 14.5 of the Agenda (Documents A67/24 and EB134/2014/REC/1, resolution EB134.R5) (continued from the eleventh meeting, section 2)

Dr GAMKRELIDZE (Georgia) said that his country was a signatory to the Minamata Convention on Mercury. He supported the draft resolution contained in resolution EB134.R5 and asked for Georgia to be added to the list of sponsors.

Mr ZHANG Yong (China) commended WHO's support for the Minamata Convention. China was in the process of industrialization and had high levels of mercury pollution. The Secretariat should provide developing countries like China with timely and appropriate capacity-building support and technical guidance, including for technology transfer, as well as support in mobilizing financial resources for the implementation of the Convention.

Mr AL ATAWI (Bahrain) expressed support for the Minamata Convention and urged the Committee to approve the draft resolution.

Ms RIOS (Argentina) agreed that plans to reduce exposure and phase out the use of mercury in the health sector should be developed. It was essential to monitor and control the risk situations that could lead to direct or indirect exposure. Argentina was committed to developing and implementing national policies aimed at prohibiting the import, extraction, production and sale of mercury and mercury-containing products and to eliminating the use of such products in the health sector. She supported the amendment proposed by the delegate of Uruguay during the previous meeting.

Mr FERDINAN TARIGAN (Indonesia) said that his country was a signatory to the Minamata Convention. It had participated in the South-East Asian subregional workshop for the ratification and early implementation of the Convention (Kuala Lumpur, March 2014), which had recommended the elimination of mercury in products and devices by 2020. Indonesia was developing a national road

map to eliminate mercury and mercury components from all products, with the focus in the health sector on clinical and laboratory devices, and stood ready to work with other countries and stakeholders to reduce mercury emissions and releases.

Mr DARR (United States of America) expressed support for the draft resolution. He appreciated the Secretariat's commitment to raising awareness of the health risks of mercury exposure and encouraged Member States to take the necessary domestic steps to implement the Minamata Convention.

Ms ALGOE (Suriname), speaking on behalf of the members of the Union of South American Nations, welcomed the involvement of WHO in the negotiations on the Minamata Convention and the inclusion in the Convention of a specific article on health aspects. As health ministries would be pivotal to implementation of the Convention, the Secretariat should provide advice and technical cooperation to support Member States in their strategies and programmes and continue to cooperate closely with the Intergovernmental Negotiating Committee, the Conference of the Parties to the Convention and other international bodies. Multilateral instruments were important tools for promoting convergence between the environmental and health dimensions, and WHO's engagement in work done under international agreements with an impact on health and the environment should be strengthened.

Dr ABUGALIA (Libya) expressed support for the draft resolution, and the Minamata Convention on Mercury, noting the extreme danger that mercury posed to human health.

Ms JIMÉNEZ VALDEZ (Mexico) welcomed WHO's contribution to developing the Minamata Convention. Her Government had already begun to implement the provisions of the Convention. Consideration should be given to the problems associated with mercury exposure among mine workers and their families and to the development of health and environmental surveillance systems. The draft resolution should make reference to financing mechanisms intended to facilitate implementation of the Convention, and the Secretariat should call on those States with the necessary resources to provide technical support and assistance to facilitate ratification. All States should develop a plan of action tailored to their circumstances.

Dr REDDY (India) expressed support for the report and the Minamata Convention.

Ms LUNA (Ecuador) recalled that, in the negotiation of the Minamata Convention, Ecuador had led the discussions resulting in the inclusion of Article 16 on health aspects and had been a sponsor of resolution EB134.R5. She supported the amendment proposed by the delegate of Uruguay.

Ms HALÉN (Sweden) expressed support for the draft resolution, as amended by Uruguay. She also welcomed the Secretariat's proposal in the report (paragraph 22) to consult Member States on identifying a set of core priority actions for the health sector.

Ms GONÇALVES (Brazil) said that important roles of health ministries in implementing the Convention would include building and strengthening national capacities for prevention and treatment of exposure to mercury; WHO's support and an intersectoral approach would be crucial. She expressed support for the draft resolution and highlighted the need for WHO to cooperate with UNEP and other entities for implementation of the health-related aspects of the Convention.

Ms NURHUSSIEN (Eritrea) said that her country supported the implementation of the Minamata Convention and would work towards the achievement of its health-related goals by 2020.

Dr MONTECILLO NARVAEZ (United Nations Environment Programme) welcomed the continued strong political support for the Minamata Convention on Mercury, an instrument that had 97 signatories and had been ratified by one country. The Convention was unique among multilateral environmental agreements as it contained a specific article on health aspects. She praised WHO's involvement in the development of the Convention and its support for global action on mercury, and called for strong political and financial engagement in implementing the Convention and cooperation at the national, regional and international levels to maximize the impact of action. She fully supported the draft resolution.

Ms SCHÜLKE (CMC – Churches' Action for Health), speaking at the invitation of the CHAIRMAN, called upon countries with small-scale gold mining to act immediately to reduce the health threats of mercury – paying particular attention to children, who were unaware of its dangers – through monitoring mercury concentrations in mining communities and capacity-building. She welcomed the adoption of the Minamata Convention, noting the crucial role of the health sector in its implementation. WHO's strong support for the Convention was encouraging, and she urged health ministries to do more to prevent, diagnose, treat and monitor the health effects of mercury.

Dr BUSTREO (Assistant Director-General) thanked Member States for their support of the report and the draft resolution and for the actions they had already initiated to implement the essence of the Minamata Convention. The Secretariat would continue to provide scientific evidence and technical advice and engage in awareness-raising concerning the public health impact of mercury. She acknowledged the leadership of Uruguay and the sponsors of the draft resolution.

The CHAIRMAN invited the Secretary to read out the proposed amendment to the draft resolution contained in resolution EB134.R5.

Dr ARMSTRONG (Secretary) recalled that the proposed addition of a new subparagraph 3(4) read: "to report to the Seventieth World Health Assembly in 2017 on progress in the implementation of this resolution."

Mr SAMAR (Algeria) said that the report to be submitted to the Seventieth World Health Assembly should focus on health issues, rather than issues relating to the mandates of other organizations.

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.¹

Contributing to social and economic development: sustainable action across sectors to improve health and health equity: Item 14.6 of the Agenda (Documents A67/25 and EB134/2014/REC/1, resolution EB134.R8)

Ms KAIRAMO (Finland) acknowledged the difficulty of translating into practice the knowledge that the environment, which was shaped by societal policies, had an important influence on health and health equity. A "health in all policies" approach was necessary, and the health sector had to act strategically and help other sectors to recognize the potential impact of their policies on population health and health equity. The focus of the 8th Global Conference on Health Promotion (Helsinki, June 2013) had been on how to implement a "health in all policies" approach, and the draft resolution

¹ Transmitted to the Health Assembly in the Committee's sixth report and adopted as resolution WHA67.11.

contained in resolution EB134.R8 called for implementation of the outcome document of the conference. She expressed her gratitude to the sponsors of the draft resolution.

Ms MVILA (Congo), speaking on behalf of the Member States of the African Region, welcomed the outcomes of the 8th Global Conference on Health Promotion and expressed support for the measures envisaged in the draft resolution. The Member States of the Region recognized the need to meet their responsibilities as identified in the Regional Health Promotion Strategy (resolution AFR/RC51/R4). Health systems strengthening in Africa must be tailored to the needs of the population, especially the poor and vulnerable, through a primary health care approach. In order to achieve universal health coverage, several obstacles would have to be overcome, including the inequitable allocation of resources and the absence of coherent health financing policies, weak and fragmented health systems and the lack of access to high-quality medicines, and poor coordination of the growing number of global health initiatives. The Member States were committed to accelerating action to achieve universal health coverage.

Dr AL-JALAHMA (Bahrain) asked the Secretariat to provide the necessary guidance and technical assistance to Member States in order for them to be able to build their capacities for taking appropriate “health in all policies” initiatives and for protecting the most vulnerable groups, especially in emergency situations and conflict areas. He supported the draft resolution.

Mr MÜHLBACHER (Austria), welcoming the draft resolution, said that the 8th Global Conference on Health Promotion had provided a useful opportunity for the exchange of experience and best practice. As part of the national health reform process in Austria, efforts were being made to promote health equity and literacy and to focus on social determinants of health. The country also aimed to formulate and implement a “health for all” strategy.

Ms RIOS (Argentina) noted that governments could only fulfil their responsibility for the health of their peoples through the adoption of appropriate health and social measures. The health sector must work with and coordinate policy-making with other sectors in order to improve water and sanitation, food safety and security, air quality and other social determinants of health, in keeping with the recommendations of the Commission on the Social Determinants of Health on action to reduce inequalities and achieve health equity. She supported the draft resolution, welcoming in particular the reference to the post-2015 development agenda.

Ms CHEN Ningshan (China) expressed appreciation of the efforts of the Secretariat to encourage intersectoral action for health promotion. China had been pursuing a multisectoral approach since the launch of its health campaign in the 1960s. Although the health of the population had improved, challenges remained with regard to sustainable action across sectors. She endorsed the draft resolution and supported the action suggested. She called upon the Secretariat to strengthen guidance and technical support to Member States, further enhance cooperation with other United Nations bodies and international organizations, and raise awareness among decision-makers in other sectors with a view to ensuring that health became a core issue in major decisions at the global and country levels.

Dr FEISUL IDZWAN MUSTAPHA (Malaysia) welcomed the development of the Framework for Country Action to support Member States in implementing a “health in all policies” approach, which should include indicators agreed across all United Nations bodies working on social determinants of health. He supported the draft resolution and urged that it build on prior instruments, including resolutions of both the Health Assembly and the United Nations General Assembly, and avoid duplication.

Mr FERDINAN TARIGAN (Indonesia) said that health equity was a shared goal and responsibility requiring multisectoral and multistakeholder commitment at the highest level. The “health in all policies” approach would promote achievement of the Millennium Development Goals and should be considered in the post-2015 development agenda. The Secretariat should provide technical support to enable countries to implement that approach and increase their commitment to integrate a health perspective into the policies in other sectors. He supported the draft resolution.

Dr AL-TAAE (Iraq), expressing support for the draft resolution, said that health development must be fully integrated with economic and social development and further that the Millennium Development Goal indicators should also be integrated in order to further social development. He also highlighted the importance of community engagement and community-based initiatives in scaling up health development at the community level.

Ms SAIZ MARTÍNEZ-ACITORES (Spain) said that action across sectors was essential to improve health and health equity. Given the link between social determinants and health, the health sector must lead the effort to ensure the adoption of the “health in all policies” approach. Noting that Spain had sponsored the draft resolution, she said that her country had already been working for some time along the lines suggested in the text.

Dr GALINDEZ (Philippines), commending the leadership of Finland in promoting the “health in all policies” approach, drew attention to some of the multisectoral initiatives being undertaken by his country to encourage the participation of other stakeholders in the health agenda and promote health equity. The Philippines supported the draft resolution and would welcome guidance from the Secretariat on capacity-building and engagement with other sectors and advocacy for the improvement of health and the achievement of health equity.

Dr MAHIPALA (Sri Lanka), speaking on behalf of the Member States of the South-East Asia Region, welcomed the draft resolution, which was of great importance to the Region. Many countries in the Region already had long experience of intersectoral action to promote better health outcomes. The Framework on Health in All Policies for South-East Asia identified four strategic directions, including national, local and issue-specific strategies for promoting health in all policies, intersectoral collaboration on health concerns and health equity. The “health in all policies” approach could be facilitated through common initiatives, such as the Millennium Development Goals, national health reform, national and international legislative frameworks for health and intersectoral and financial mechanisms.

Dr GALVEZ (Panama), noting the impact of public policies on health and health equity, said that governments must redouble their efforts to implement coordinated action across sectors and countries in order to protect health and endow health systems with the necessary capacity to respond to health needs. Sustainable action across sectors was a core element in the management of his country’s health policies and constituted the cornerstone for improvement of health indicators, particularly among the most disadvantaged people in society.

Miss ORRATAI WALEEWONG (Thailand) observed that it was not always easy to put the “health in all policies” approach into practice. In her country’s experience, key success factors were engagement and ownership of all stakeholders from policy formulation to implementation, as well as institutional capacity, transparency and accountability. She welcomed the Helsinki Statement on

Health in All Policies and the paper on the Framework for Country Action.¹ She supported the draft resolution, and her delegation would be pleased to participate in consultations on the Framework.

Ms DOAN PHUONG THAO (Viet Nam) said that her country recognized the important role of non-health sectors and the need for action across sectors to improve health equity. She supported the adoption of the draft resolution in principle; as all Member States must commit to developing sustainable institutional capacity, she recommended that subparagraph 2(3) be amended to begin: “to develop sustainable institutional capacity with adequate knowledge and skills in assessing health impacts of policy initiatives in all sectors, identifying solutions ...”. In subparagraph 2(5) “and monitoring” should be replaced with “, monitoring and supervision” in order to highlight the role of civil society in supervising policies across sectors.

Mr ESPINOSA SALAS (Ecuador) said that his country wished to be added to the list of sponsors of the draft resolution.

Ms GONÇALVES (Brazil) said that the World Conference on Social Determinants of Health and the United Nations Conference on Sustainable Development had reaffirmed the importance of both health as an engine of sustainable socioeconomic development and intersectoral action in health policy-making. The Helsinki Statement on Health in All Policies identified actions to foster synergy between the health, economic and environmental sectors with a view to promoting equity. In the interests of advancing the achievement of that objective, Brazil had wished to join the list of sponsors of the draft resolution.

Ms Yu-Hsuan LIN (Chinese Taipei) agreed that health and health equity should be achieved through sustainable action across sectors. Implementing a “health in all policies” approach required political commitment from leaders at all levels, dissemination of evidence to guide policy-making and assessment of the health impacts of all policies of all sectors. In Chinese Taipei the health and social welfare systems had been integrated with a view to promoting synergies, enhancing the accountability of policy-makers for health impacts and enhancing health equity.

Ms BILAL (International Federation of Medical Students’ Associations), speaking at the invitation of the CHAIRMAN, said that the Health in All Policies Framework encouraged equity through the promotion of intersectoral collaboration and should ensure that the well-being of peoples was not considered a matter for the health industry only. However, the absence of a specific statement facilitating institutionalized accountability was a concern. She called on Member States to translate the “health in all policies” approach into effective legislation, in order to ensure that public health and equity were promoted in a sustainable manner and that health was prioritized in the post-2015 development agenda.

Dr LAU (International Society of Radiology), speaking at the invitation of the CHAIRMAN, said that more than two thirds of the global population had no access to basic radiology, even though that underpinned much of patient care and could contribute to the achievement of at least four Millennium Development Goals. He urged the Health Assembly to adopt a resolution reinstating a coordinating radiologist position in the Secretariat and initiating programme funding to increase access to safe and appropriate basic radiology in order to improve health and health equity.

Dr BETTCHER (Prevention of Noncommunicable Diseases), thanking delegates for their valuable comments and feedback, said that the Secretariat was fully committed to implementing the resolution and, in particular, to preparing, in consultation with Member States, United Nations

¹ Health in all policies: Helsinki statement. Framework for country action. Geneva: World Health Organization; 2014.

organizations and other relevant stakeholders, a practical Framework for Country Action, for adaptation to different contexts, taking into account the Helsinki Statement on Health in All Policies. It would also collaborate with partners and Member States to build and maintain adequate and sustainable institutional capacity and skills at the regional and country levels in order to improve health and health equity outcomes through action across sectors. He looked forward to receiving ongoing guidance and support from Member States in that regard. He expressed special appreciation to the Government of Finland for its leadership in the domain of “health in all policies” and thanked the many sponsors of the draft resolution.

The CHAIRMAN invited the Secretary to read out the proposed amendment to the draft resolution.

Mr ROBERTS (Assistant Secretary) said that Viet Nam had proposed that in subparagraph 2(3) the words “as appropriate, and maintain adequate” be removed, that “with adequate knowledge” be inserted after “capacity”, that “implications” be replaced by “impacts”, and that “exploring” be replaced by “identifying”, such that the subparagraph would read: “to develop sustainable institutional capacity with adequate knowledge and skills in assessing health impacts of policy initiatives in all sectors, identifying solutions ...”. Viet Nam had also proposed that “implementation and monitoring” in subparagraph 2(5) be replaced with “implementation, monitoring and supervision”.

Professor HALTON (Australia), recalling that the draft resolution had been the subject of lengthy debate and compromise by the Executive Board, asked whether the delegate of Viet Nam might demonstrate flexibility and retain the existing text. She had difficulties with the proposed amendments, in particular the deletion of “as appropriate” in subparagraph 2(3), which could pose problems for some developed countries which already had in place some of the mechanisms called for, and the addition of “and supervision” in subparagraph 2(5).

Ms DOAN PHUONG THAO (Viet Nam) said that she could agree to withdraw her proposed amendment to subparagraph 2(5). As to subparagraph 2(3), she wished to add the words “with adequate knowledge” after “capacity”. In response to a clarification from the DIRECTOR-GENERAL, she agreed to retain the words “as appropriate”.

The CHAIRMAN said that, in the absence of any objection, he would take it that the Committee wished to approve the draft resolution, as amended.

The draft resolution, as amended, was approved.¹

3. PREPAREDNESS, SURVEILLANCE AND RESPONSE: Item 16 of the Agenda (continued)

Implementation of the International Health Regulations (2005): Item 16.1 of the Agenda (Documents A67/35, A67/35 Add.1 and EB134/2014/REC/1, resolution EB134.R10)

Mr FERDINAN TARIGAN (Indonesia), speaking on behalf of the Member States of the South-East Asia Region, said that significant progress had been made in the Region in the detection and reporting of public health events and strengthening of core capacities since the revised International Health Regulations (2005) had come into force. All Member States of the Region had

¹ Transmitted to the Health Assembly in the Committee’s sixth report and adopted as resolution WHA67.12.

requested a two-year extension for implementation of core capacities. Two countries had already declared full compliance, but progress was uneven. He therefore called for increased efforts to support countries in establishing and maintaining core capacities; strengthen intersectoral collaboration at the international, national and subnational levels with all concerned stakeholders; and facilitate the mobilization of financial and technical resources for the establishment of core capacities. He welcomed the conclusion of the Strategic Advisory Group of Experts on immunization that a single dose of yellow fever vaccine was sufficient to confer life-long protection against the disease. He supported the draft resolution contained in resolution EB134.R10.

Dr AL-TAAE (Iraq), noting that important issues to be considered within the framework of the International Health Regulations (2005) included poliomyelitis, infections with the Middle East respiratory syndrome coronavirus (MERS-CoV), food safety and mass gatherings, highlighted the need for intersectoral and intercountry collaboration in applying the Regulations, and drew attention to collaboration between Afghanistan, the Islamic Republic of Iran, Iraq, Pakistan and WHO. He also noted the importance of the Secretariat's role in capacity-building.

Dr GAMKRELIDZE (Georgia) noted with satisfaction that Georgia was among the countries that had met the core capacity requirements of the Regulations by 2012. He welcomed the Global Health Security Agenda launched in February 2014, which provided a global framework for detecting and responding to emerging health threats, and expressed support for the draft resolution.

Mr LUTNÆS (Norway) said that, despite the progress made, it was worrying that many countries had not yet established the core capacities under the International Health Regulations (2005). Norway supported the establishment by the Secretariat of a country-twinning programme to facilitate the exchange of best practices. It was working to identify areas in low- and middle-income countries that could be improved through bilateral and multilateral initiatives such as the Global Health Security Agenda, which involved 34 countries, including Norway. Such initiatives must, however, be consistent with the principles of the Regulations and reinforce WHO's efforts to improve core capacities. He supported the draft resolution.

Mr KRANIAS (Greece), speaking on behalf of the European Union and its Member States, Turkey, the former Yugoslav Republic of Macedonia, Montenegro, Iceland, Serbia, Albania, Bosnia and Herzegovina, Ukraine, the Republic of Moldova, Armenia and Georgia, said that recent outbreaks of disease underlined the importance of the full implementation of the International Health Regulations (2005). The Union's Decision on serious cross-border threats to health would help to strengthen preparedness and response, and all international initiatives to strengthen the implementation of the Regulations, including the Global Health Security Agenda, were welcome. The Secretariat's coordination of international efforts was crucial. The Regulations would remain a major component of preparedness and response as well as health system strengthening, and the Secretariat should intensify its work on putting resolution WHA65.23 into practice and its support for Member States in their implementation of the Regulations. Welcoming the technical briefing on strengthening health security by implementing the Regulations held during the current Health Assembly, he called on States to renew their commitment to the implementation of the Regulations.

Dr AMMAR (Lebanon) said that, for some of the Member States requesting extensions, civil unrest and political instability were the biggest obstacles to establishment of the core capacities. In Lebanon, for example, armed conflict and mass migration had hindered capacity-building and enforcement of the Regulations at points of entry and led to human resources shortages. As that situation was unlikely to improve in the near future, the June 2016 deadline might not be realistic for some countries unless exceptional measures were taken. Recent experiences had revealed weakness in coordination between National IHR Focal Points, notification of WHO, and sending of specimens to

reference laboratories. Coordination mechanisms should be reviewed and Focal Points better trained in communication.

Ms CHO Soo-nam (Republic of Korea) said that recent health threats from avian influenza A(H7N9) and MERS-CoV had made the International Health Regulations (2005) more important than ever. Extensions should be granted for the implementation of core capacities under the Regulations, but great efforts by both States Parties and the Secretariat would be needed in order to meet the 2016 deadline. The Republic of Korea planned to establish an emergency committee, in accordance with the amended Regulations. Her Government would conduct research to determine whether it would apply the proposed amendment to the Regulations (2005) regarding yellow fever vaccination.

Ms GURBANOVA (Azerbaijan) said that monitoring infectious diseases had become increasingly important in the face of outbreaks and threats of potential pandemics associated with globalization, increased transport and increasing migration. Modern electronic disease surveillance systems were needed for that purpose. Azerbaijan had recently introduced such a system in order to improve data collection and analysis, and provide real-time information for analysis and decision-making. The system also facilitated information-sharing with other countries and with the Regional Office for Europe. Azerbaijan was prepared to share its experience with interested countries and partners.

Dr AL-JALAHMA (Bahrain) thanked the Strategic Advisory Group of Experts on immunization and the Director-General for providing support to countries in their implementation of the International Health Regulations (2005). Bahrain had robust surveillance and reporting mechanisms and a good system for capacity-building. Recent evaluation, with the assistance of six WHO experts, of the plan of action that had been prepared for applying the Regulations had concluded that the country could build up its capacities in order to apply the Regulations and that it did not need to request any extension of the deadline. She supported the draft resolution.

Dr MANAMOLELA (Lesotho), speaking on behalf of the Member States of the African Region, noted the exemplary response to MERS-CoV and the importance of the International Health Regulations (2005) as the main legal framework for responding to such epidemics. The Member States had taken note of the recommendation of the Strategic Advisory Group of Experts on immunization regarding yellow fever vaccination and would implement measures to accept vaccination certificates from travellers vaccinated at least 10 days before arrival. They recommended vigilance, however, and the establishment of early warning systems to contain any infections that might occur. She supported the draft resolution.

Dr FEISUL IDZWAN MUSTAPHA (Malaysia), acknowledging the Secretariat's response to the emergence of MERS-CoV, expressed concern that even after two years many questions about the virus and its transmission in humans remained unanswered. The recent increase in reports of cases, including imported and travel-associated cases, was also of great concern. The Secretariat should intensify efforts to improve knowledge about the virus.

Mr ZHANG Yong (China) expressed appreciation of the Secretariat's coordination of the response to MERS-CoV and other public health risks. Following the detection of cases of human infection with avian influenza A(H7N9) virus in April 2013, his Government had strengthened information-sharing and technical cooperation, as well as sharing of virus strains with WHO and relevant countries. Chinese health authorities and other relevant bodies were cooperating to build core public health capacities in order to meet the targets for 2014. Building core capacities was a long-term, sustained process, and the Secretariat should therefore continue to provide technical support to enable countries to fill gaps. He endorsed the proposed revisions to Annex 7 to the Regulations regarding yellow fever vaccination.

Mr BOISNEL (France), expressing support for the draft resolution, said that the International Health Regulations (2005) had proved their value as an international framework for responding to health threats associated with globalization and drew attention to the need for States Parties to have core capacities in place. Full implementation of the Regulations was an ongoing objective for France. The Secretariat must continue to support States Parties in implementing the Regulations. He welcomed initiatives aimed at accelerating that work, such as the Global Health Security Agenda. One component of preparedness and response in the context of the Regulations was the Pandemic Influenza Preparedness Framework, which he fully supported.

Dr HANSA RUKSAKOM (Thailand) supported the proposed revisions to Annex 7 of the Regulations. The large number of States Parties that had requested extensions of the deadline for establishing the core capacities demanded urgent attention from all relevant national and international actors. A clear and adequately funded capacity-building plan was needed; however, it remained the responsibility of States Parties to fill gaps and strengthen core capacities. Successful implementation of the Regulations hinged on the capacity of the National IHR Focal Points, which should receive sustained political and financial support, in particular to facilitate cross-sectoral collaboration. That was an important support role for the Secretariat.

Dr REDDY (India) said that India remained committed to the implementation of the International Health Regulations (2005) and had made good progress in establishing the core capacities. Having completed a self-assessment questionnaire in 2013, the country had requested an extension to 2016. He supported the draft resolution and agreed with the revised recommendations on yellow fever vaccination for travellers from countries where the disease was endemic. However, the proposal regarding revaccination of travellers from countries where yellow fever was not endemic should be reviewed, given that immunity levels in travellers from such countries, including India, would be lower because they would not have been frequently exposed to the virus. The Secretariat should continue to support national plans for the implementation of the Regulations.

Ms BONNER (Germany), noting that Germany had provided laboratory experts and financial support to help to contain the Ebola virus outbreak in Guinea, said that global health depended on global implementation of the International Health Regulations (2005), whose application must be a continuous process. Even after putting the core capacities in place, countries would need to maintain and further develop them in order to keep up with new threats and technologies. The exchange of information and alerts on threats to public health was the backbone of the Regulations, and she called on all Member States to continue to share timely and relevant information. She supported the draft resolution, which would strengthen cooperation and improve application of the Regulations.

Mr CANDIA (Paraguay), speaking on behalf of the members of the Union of South American Nations, welcomed the report on the status of implementation and the proposed draft resolution. He proposed that an additional function of the IHR Review Committee be to advise the Director-General on how to support Member States requesting extensions of the deadline to establish core capacities and recommended a comprehensive evaluation of existing capacities and gaps. Self-assessment was vital to continuously improving core capacities. With regard to port and airport certification, he asked the Secretariat for the latest working versions of the relevant guidelines.

He supported the recommendation to eliminate the requirement for revaccination against yellow fever, but requested that an updated map be produced that reflected Member States' assessments of the areas at risk. The content and scope of Annex 7 should then be revised on that basis. He also requested that progress in implementing the Regulations be reviewed by the Executive Board at its 136th session, in January 2015.

Dr VALVERDE (Panama), noting that Panama belonged to the National IHR Focal Points network, which facilitated timely sharing of public health information, echoed the call for a review of the yellow fever risk map, as the current map did not reflect the fact that some countries had been free of the disease for more than 40 years.

Ms VACA (Colombia) supported the draft resolution and the recommendation that the validity of a certificate of vaccination against yellow fever after a single dose of vaccine extend for the life of the person vaccinated. The risk map for yellow fever, however, should be reviewed. A complete review of Annex 7 should be considered and the possibility of including requirements concerning other vaccines and risk areas be examined.

Ms CAMERON (United States of America) said that global collaboration and transparency were imperative in responding to global health threats and commended the efforts of the Secretariat and States Parties to ensure that the International Health Regulations (2005) continued to be used as intended: a legally binding global framework for detecting and responding to diseases and public health risks and emergencies. In line with resolution WHA65.23 and its call for increased collaboration among States Parties, her Government had championed the development of the Global Health Security Agenda to identify, refine and focus actions to accelerate the implementation of the Regulations. States Parties should prioritize their commitment to the Regulations in order to ensure introduction and maintenance of the required core capacities by 2016. Her country continued to maintain its core capacities. She supported the draft resolution.

Ms JIMÉNEZ VALDEZ (Mexico) affirmed her country's commitment to implementation and maintenance of the required core capacities; it would not be requesting an extension of the deadline. Mexico maintained close communications with WHO regional offices to share information and respond to emerging issues. The experience of its National IHR Focal Point, which was in constant contact with PAHO, could be shared with others in the Region of the Americas. Mexico would continue to participate actively in regional and global meetings and workshops on matters relating to implementation of the Regulations.

Ms DOAN PHUONG THAO (Viet Nam) welcomed the Secretariat's leadership in the response to MERS-CoV and other public health threats and its support for strengthening core capacities. The updated Event Information Site for National IHR Focal Points had improved access to information on emerging public health events. The recently established public health emergency operations centre network promoted collaboration between Member States and international organizations. The Secretariat should continue to support the transfer of technology, knowledge and skills in priority areas. She had no objection to the proposed revision of Annex 7 of the Regulations and supported the draft resolution.

Ms IBRAHIM (Maldives) said that, although her country had made some progress, particularly in laboratory capacity and infection control, capacities relating to public health legislature, preparedness and surveillance needed further strengthening. Like many small countries, Maldives had limited human resources, and needed cross-sectoral, regional and intercountry collaboration to augment their numbers to an appropriate size. Adequate resources must be allocated for the implementation of the core capacities in order to ensure global health security.

Ms GONÇALVES (Brazil) welcomed the improvements to the Event Information Site for National IHR Focal Points, which was a fundamental tool in multilateral cooperation, and commended the work of the Strategic Advisory Group of Experts on immunization. She supported the draft resolution and the proposed revisions to Annex 7. Brazil would continue to support other countries in implementing the Regulations through South-South cooperation and support for the Secretariat's work.

Mr MERCADO (Argentina) requested a longer period for consideration of the guidelines relating to port and airport certification, which should be discussed and approved by Member States. He also requested that the Secretariat make available information on all initiatives by Member States, other organizations and WHO to implement the International Health Regulations (2005).

Mr AGAFONOV (Russian Federation) congratulated the Secretariat for its work on the outbreaks of MERS-CoV, including the development of protocols and response plans and the provision of support to affected countries. The preparation of technical guidelines for assessing and managing the risks associated with international mass gatherings was an important aspect of the Secretariat's work in relation to the Regulations. He thanked the Secretariat for its support of a seminar recently held in the Russian Federation to train ship inspectors from various countries on the issuance of ship sanitation certificates. Technical guidelines for land-based points of entry should be developed and made available as soon as possible. Although the Russian Federation had met the deadline for implementation of the core capacities under the Regulations, many countries had been unable to do so, and he supported the proposal to extend the deadline where necessary. He supported the draft resolution.

Ms NURHUSSIEN (Eritrea), affirming her Government's support for full implementation of the International Health Regulations (2005), thanked the Secretariat for its prompt responses in emergency situations and for its capacity-building support.

Dr DAHL-REGIS (Bahamas), speaking on behalf of the member countries of the Caribbean Community, thanked the Secretariat and the Regional Office for the Americas for their continued efforts to support small island countries with limited ability to meet the core capacity requirements. The new flexibilities in the Regulations that allowed countries to partner with other countries to ensure needed capacities, in particular with respect to radiological and chemical preparedness, were welcome. She sought continued support from the Secretariat and the Pan American Sanitary Bureau in strengthening the newly established Caribbean Public Health Agency. She supported the draft resolution.

Dr Kuy-Lok TAN (Chinese Taipei), expressing support for the draft resolution, said that Chinese Taipei had met the core capacity requirements. Two international airports and ports had been evaluated by international experts in 2011 and 2013 and five more were being evaluated in 2014. She welcomed the Event Information Site for National IHR Focal Points, which had provided current information on MERS-CoV and human infection with avian influenza A(H7N9). Chinese Taipei would continue to contribute to global public health security under the framework of the International Health Regulations (2005).

Dr NUTTALL (Global Capacities, Alert and Response) acknowledged the comments and commended Member States' efforts in developing and maintaining the core capacities, noting in particular the various initiatives mentioned and the bilateral support provided for the implementation of the Regulations. The Secretariat would continue to support States Parties in tracking specific events, monitoring and providing appropriate guidance. In response to specific questions and requests, she said that the Strategic Advisory Group of Experts on immunization had considered that the current recommendations were adequate for travellers from countries in which yellow fever was not endemic. The yellow fever risk map was regularly updated by an expert group as additional information became available. The Review Committee on the Functioning of the International Health Regulations (2005) would advise the Director-General on how best to support States Parties in implementing the Regulations. The guidelines on port and airport certification would be circulated to all Member States through their National IHR Focal Points, in collaboration with the regional offices. Guidelines on ground crossings were being developed and were expected to be available in early 2015.

The CHAIRMAN said that, in the absence of any objection, he took it that the Committee wished to approve the draft resolution contained in resolution EB134.R10.

The draft resolution was approved.¹

4. WHO REFORM: Item 11 of the Agenda (continued)

Framework of engagement with non-State actors: Item 11.3 of the Agenda (Documents A67/6 and A67/54) (continued from the tenth meeting, section 1)

The CHAIRMAN drew attention to a revised version of the draft decision on the framework of engagement with non-State actors reflecting the amendments agreed during the tenth meeting. The text read:

The Sixty-seventh World Health Assembly,

Having considered the report on the framework of engagement with non-State actors;² welcoming the progress made on the draft framework of engagement with non-State actors by the Sixty-seventh World Health Assembly; underlining the importance of an appropriate framework for engagement with non-State actors for the role and work of WHO; and recognizing that further consultations **and discussions are** ~~is~~ needed on issues including conflict of interest and relations with the private sector,

(1) ~~called upon~~ **DECIDED** that Member States ~~to should~~ submit their specific follow-up questions to the Director-General by ~~6~~ **17** June 2014;

(2) **REQUESTED** the Director-General:

(1) to prepare a **comprehensive** report in response to the Health Assembly's comments and the follow-up questions raised; **including clarification thereon from the Secretariat, by the end of July 2014;**

~~(2) to consult further with Member States during the regional committees, in 2014 on the basis of the draft framework of engagement with non-State actors and the report referred to in subparagraph (2)(1) above;~~

~~(3) to submit an account of the further consultations undertaken in 2014 and the proposed way forward to the Executive Board at its 136th session in January 2015.~~

(3) **DECIDED** that the regional committees in 2014 should discuss this matter, with reference to the draft framework of engagement with non-State actors (A67/6) and the report referred to in subparagraph (2)(1) above; and requested that regional committees submit a report on their deliberations to the Sixty-eighth Health Assembly, through the Executive Board;

(4) **REQUESTED** the Director-General:

(1) to submit a paper to the 136th session of the Executive Board in January 2015, ensuring that Member States receive it by mid-December 2014, to allow them sufficient time to study the paper and be better prepared for the discussions and deliberations.

¹ Transmitted to the Health Assembly in the Committee's sixth report and adopted as resolution WHA67.13.

² Document A67/6.

Dr VALLEJO (Ecuador) proposed that in order to better reflect the discussions that had taken place in earlier meetings, in paragraph (1) “comments and” should be inserted between “follow-up” and “questions” and that subparagraph (2)(1) should be amended to read: “to prepare a comprehensive report of the comments made by Member States during the Sixty-seventh World Health Assembly and the follow-up comments and questions raised, including clarification thereon from the Secretariat in response by the end of July 2014;”.

Dr REDDY (India), Mr MERCADO (Argentina), Mr ROSALES LOZADA (Plurinational State of Bolivia), Ms JIMÉNEZ VALDEZ (Mexico), Mr MATUTE HERNANDEZ (Colombia), Ms GONÇALVES (Brazil) and Dr COITÍÑO (Uruguay) supported the amendments proposed by the delegate of Ecuador.

Ms BLACKWOOD (United States of America) asked the Secretariat to reread the amendments proposed by the delegate of Ecuador. In addition, she asked whether an account of the discussions that had taken place in the drafting group would be included in the Director-General’s comprehensive report.

Professor HALTON (Australia) asked the Secretariat to clarify the amendments proposed by the delegate of Ecuador.

Dr MCLELLAN (Assistant Secretary), in response to a request from the CHAIRMAN, said that with the amendments proposed by the delegate of Ecuador paragraph (1) would read: “DECIDED that Member States should submit their specific follow-up comments and questions to the Director-General by 17 June 2014” and subparagraph 2(1) would read: “to prepare a comprehensive report of the comments made by Member States during the Sixty-seventh World Health Assembly and the follow-up comments and questions raised, including clarification thereon from the Secretariat in response by the end of July 2014;”.

Dr DAHL-REGIS (Bahamas) said that the proposed amendments as she understood them would not change the intent of the draft decision. If that were indeed the case, she was prepared to accept the draft decision, as amended.

The DIRECTOR-GENERAL confirmed that the proposed amendments would not affect the substance of the draft decision and encouraged Member States to support it.

In response to the delegate of the United States of America, she said that comments made in the drafting group would be included, to the best of the Secretariat’s ability. However, she urged Member States to restate their questions and comments in writing before 17 June 2014 in order to ensure that they were included.

The CHAIRMAN took it that, in the absence of any objection, the Committee wished to approve the draft decision, as amended.

The draft decision, as amended, was approved.¹

¹ Transmitted to the Health Assembly in the Committee’s sixth report and adopted as decision WHA67(14).

5. PREPAREDNESS, SURVEILLANCE AND RESPONSE: Item 16 of the Agenda (resumed)**Pandemic influenza preparedness: sharing of influenza viruses and access to vaccines and other benefits:** Item 16.2 of the Agenda (Documents A67/36 and A67/36 Add.1)

Dr TAFANGY (Madagascar), speaking on behalf of the Member States of the African Region, said that pandemic influenza preparedness was a priority for every Member State in the Region. As pandemic influenza remained a global threat, Member States must: be prepared to respond to it by implementing the International Health Regulations (2005) and integrated disease surveillance and response; recognize the importance of timely virus sharing for vaccine development; and strengthen pandemic and epidemic preparedness and response capacities through updated contingency plans. Influenza surveillance must be sustained and continually improved. Congratulating the Secretariat for its work on pandemic influenza preparedness, he encouraged the Pandemic Influenza Preparedness Advisory Group to continue its work.

Dr AL-TAAE (Iraq) called for one composite influenza surveillance package, based on information from sentinel sites and covering avian influenza A(H1N1), A(H5N1), A(H7N9) and seasonal influenza viruses. WHO had a vital role to play in facilitating such activities, providing technical support to enhance laboratory technologies, including diagnosis using real-time polymerase chain reaction assays, and in frequently reviewing accreditation certificates. WHO should also promote operational research at the national, regional and interregional levels, focusing in particular on influenza A(H7N9) virus and the availability of detection kits.

Mr AGAFONOV (Russian Federation) said that the Pandemic Influenza Preparedness (PIP) Framework had led to more transparent sharing of biological materials and welcomed the approved formula and methodology for determining the distribution of the Partnership Contribution. The criteria for determining recommended country recipients should continue to be refined with a view to ensuring the rational and fair use of Partnership Contribution resources. He supported the work to conclude negotiations on standard material transfer agreements 2 (SMTA 2), which would facilitate cooperation with the pharmaceutical industry, and noted the work of WHO's legal team to speed up that process. He also supported the development of guidelines for the use of influenza virus genetic sequence data within the PIP Framework and affirmed his country's wish to participate in the Technical Expert Working Group on that issue.

Mr ACEP SOEMANTRI (Indonesia) welcomed the work of the Advisory Group to facilitate implementation of the PIP Framework. The emergence of novel influenza viruses meant that the imminent threat of a pandemic persisted, and the PIP Framework therefore remained relevant; Member States would need to continue working to improve their pandemic preparedness capacities. He welcomed the preliminary report of the Technical Expert Working Group on genetic sequence data and encouraged the development of guidelines on handling such data under the Framework. He welcomed the draft guideline principles on the Partnership Contribution and the use of its resources. WHO and other international partners should continue to work towards full implementation of the Framework, including the provisions on benefit sharing.

Mr MAMACOS (United States of America) welcomed the progress in implementing the PIP Framework and the Partnership Contribution and the transparency evident in the report. The improved communication with stakeholders and efforts to establish synergies between the PIP Framework, the Global Action Plan for Influenza Vaccines and the International Health Regulations (2005) were also commendable. He encouraged all stakeholders to plan and strengthen vaccine deployment capacities, building on the WHO Pandemic Influenza A(H1N1) Vaccine Deployment Initiative.

Dr AL HAJERI (Bahrain) said that her Government had taken several measures for pandemic influenza preparedness through building up its monitoring and laboratory capacities. Monitoring had been strengthened at national level for detection of influenza-like outbreaks and acute respiratory syndromes and investigation of viruses. The country's one specialized laboratory was accredited by WHO as the national influenza centre. Its activities included genetic sequencing. She support WHO's efforts in influenza preparedness, including coordination of virus sharing and tracing and support for vaccine development.

Dr HANSA RUKSAKOM (Thailand), commending the progress in implementing the PIP Framework, pointed out that vaccine production capacity remained concentrated in a few high-income countries and the global supply was inadequate. The Global Action Plan for Influenza Vaccines had increased vaccine production, proving that boosting manufacturing capacity in developing countries was feasible, and the Secretariat should continue its support for the Plan, with financing from Partnership Contribution resources. Effective planning and management would be needed in order to redress the mismatch between annual budgets and long-term demand.

Mr LUTNÆS (Norway) said that the Secretariat should continue to focus on implementing the PIP Framework, including collection and use of Partnership Contribution funds to enhance pandemic preparedness and the conclusion of legally binding agreements with vaccine producers. Member States should also continue to strengthen pandemic preparedness at the national level, drawing on lessons learnt from pandemic A(H1N1) 2009.

Dr REN Minghui (China) welcomed WHO's efforts to establish a transparent and equitable framework for virus sharing, noting that several Chinese vaccine manufacturers were engaged in standard material transfer agreement 2 (SMTA 2) negotiations. Following the detection of human infections with avian influenza A(H7N9) virus, China had launched a mechanism for sharing virus strains; 24 strains had been shared with 11 national laboratories and regions, including four pandemic research and cooperation centres. The Secretariat should promote implementation of the PIP Framework, improve data, facilitate national implementation plans and adopt measures to improve communication among Member States.

Dr LLACUNA (Philippines) commended the Partnership Contribution implementation plan: 2013–2016, which would facilitate engagement with industry associations and manufacturers. He supported the recommendations of the Advisory Group on the use of Partnership Contribution resources and finalization of the draft document on Regional Office Recommended Country Recipients. Highlighting the need for transparency in the distribution of resources, he expressed the hope that the development of links with industry would enhance Member States' capacity-building and pandemic preparedness efforts.

Ms GONÇALVES (Brazil) said that the PIP Framework strengthened WHO's influenza surveillance and response capabilities, improving virus sharing and access to vaccines and other benefits. Care should be taken to avoid conflicts of interest in the selection of countries to receive Partnership Contribution resources and in the establishment of selection criteria. SMTA 2 negotiations should be transparent and in line with the WHO reform process.

Dr Kuy-Lok TAN (Chinese Taipei) said that Chinese Taipei had followed its influenza pandemic preparedness and response plan in responding to the influenza A(H7N9) outbreak. Chinese Taipei had confirmed four imported cases. She thanked Japan and the United States of America for sharing virus strains. Chinese Taipei had been developing an influenza A(H7N9) vaccine since 2013 and would share it with the international community when appropriate. It would continue to invest in vaccine research and production and would welcome international cooperation in that endeavour.

Mrs BARRIA (Medicus Mundi International – International Organisation for Cooperation in Health Care), speaking at the invitation of the CHAIRMAN, called on the Secretariat to expedite the signing of standard material transfer agreements and to urge manufacturers of vaccines and diagnostic materials to pay their Partnership Contributions promptly. The Secretariat should also ensure that the use of genetic sequence data was subject to benefit-sharing requirements under the PIP Framework. Such data should never be subject to intellectual property claims, and she noted with concern that, if granted, pending patents might well impede access to diagnostic and therapeutic agents for the MERS coronavirus.

Dr BRIAND (Pandemic and Epidemic Diseases) thanked Member States for their comments regarding implementation of the PIP Framework and for continuing to share influenza viruses through the Global Influenza Surveillance and Response System. She also thanked industry partners for their contributions to implementation of the PIP Framework. She acknowledged the need for transparency regarding implementation of the Framework and said that tools were being developed for timely sharing of information with stakeholders. She noted the importance of synergies between the Global Action Plan for Influenza Vaccines, the International Health Regulations (2005) and the PIP Framework. The Secretariat remained committed to ensuring equitable sharing of virus strains and of the resulting benefits and welcomed Member States' support for the technical expert working group on genetic sequence data and proposals to ensure close communication between WHO and industry representatives.

The CHAIRMAN took it that the Committee wished to note the reports contained in documents A67/36 and A67/36 Add.1.

The Committee noted the reports.

6. ORGANIZATION OF WORK

Professor HALTON (Australia) recalled that during its 134th session the Executive Board had discussed the challenges of managing long agendas, and it had been suggested that the item on progress reports, for example, might be dealt with more efficiently. As there were several other important issues remaining on the Committee's agenda, she suggested that delegates might consider submitting their statements in writing for publication by the Secretariat.

The CHAIRMAN said that, if he heard no objection, the Committee agreed to this approach.

It was so agreed.

7. PROMOTING HEALTH THROUGH THE LIFE COURSE: Item 14 of the Agenda (resumed)

Monitoring the achievement of the health-related Millennium Development Goals: Item 14.1 of the Agenda (Document A67/19)

- **Health in the post-2015 development agenda:** Item 14.1 of the Agenda (Document A67/20) (continued from the seventh meeting, section 1)

The CHAIRMAN drew attention to a revised version of the draft resolution proposed by the Member States of the African Region on health in the post-2015 development agenda, recalling that a drafting group had been established to agree on a consensus text. The revised text read:

The Sixty-seventh World Health Assembly,

PP1 Having considered the report on Monitoring the achievement of the health-related Millennium Development Goals: Health in the post-2015 development agenda;¹

PP2 Reaffirming the Constitution of the World Health Organization (WHO), 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 conditions;

PP3 Reaffirming also the principles of the United Nations Millennium Declaration adopted by the United Nations General Assembly in resolution 55/2, including human dignity, equality and equity, and stressing the need for their reflection in the post-2015 development agenda;

PP4 Recalling the United Nations General Assembly resolution 66/288 “The future we want”, which recognizes that health is a precondition for and an outcome and indicator of all dimensions of sustainable development;

PP5 Stressing also that concerns related to health equity and rights should be addressed in efforts to achieve the Millennium Development Goals;

PP6 Recalling resolution WHA66.11 on health in the post-2015 development agenda, which urged Member States to ensure that health is central to the post-2015 UN development agenda;

PP7 Reaffirming the need to sustain current achievements and intensify efforts in those countries where accelerated progress is needed towards achievement of the health-related Millennium Development Goals, especially maternal, newborn and child health;

PP8 Cognizant also of the burden of maternal, newborn and child morbidity and mortality, communicable diseases, including HIV/AIDS, tuberculosis, malaria and neglected tropical diseases, emerging diseases and the rising burden of noncommunicable diseases and injuries;

PP9 Acknowledging that universal health coverage implies that all people have access without discrimination to nationally determined sets of the needed promotive, preventive, curative, palliative and rehabilitative essential health services and essential, safe, affordable, effective and quality medicines, while ensuring that the use of these services does not expose the users to financial hardship with a special emphasis on the poor, vulnerable and marginalized segments of the population;

PP10 Recognizing the importance of implementing all relevant internationally agreed commitments, including the Beijing Platform for Action, the Programme of Action of the International Conference on Population and Development and the review conferences to date, the political declaration on the prevention and control of noncommunicable diseases, and the

¹ Document A67/20.

Political Declaration on HIV and AIDS and United Nations General Assembly resolution 67/81 in achieving provision of universal health coverage and improved health outcomes;

PP11 Recognising the importance of strengthening health systems and building capacities for broad public health measures, health protection and addressing determinants of health towards attaining equitable universal coverage;

PP12 Emphasizing that policies and actions in sectors other than health have a significant impact on health outcomes and vice-versa, hence the need to identify synergies between policy objectives in the health and other sectors through a whole-of-government, whole-of-society and Health in All Policies approach to the post-2015 development agenda;

PP13 Reiterating our determination to take action on social determinants of health as collectively as agreed by WHA62.14;

PP14 Recognizing the importance of strengthened international cooperation and honouring commitments towards national and international health financing, and ensuring that international development cooperation in health is effective and aligned with national health priorities;

PP15 Recognizing that the monitoring of health improvement should include measuring health systems performance as well as health outcomes that capture healthy life expectancy, mortality, morbidity and disability;

PP16 Recognizing the importance of the health workforce and its essential contribution to health systems functioning and the need for continued commitment to relevant WHA resolutions, in particular WHA63.16 on the WHO Global Code of Practice on the International Recruitment of Health Personnel,

OP1 URGES Member States,¹ in the context of health in the post-2015 development agenda:

- (1) to engage actively in discussions on the post-2015 development agenda, respecting the process established by the United Nations General Assembly;
- (2) to ensure that health is central to the post-2015 development agenda;
- (3) to ensure that the post-2015 development agenda will accelerate and sustain progress towards the achievement of health-related MDGs including, child, maternal, sexual and reproductive health, nutrition, HIV, tuberculosis and malaria;
- (4) to recognize that additional attention needs to be paid to newborn health and neglected tropical diseases;
- (5) to incorporate into post-2015 agenda the need for action to reduce preventable and avoidable burden of mortality, morbidity and disability related to noncommunicable diseases, and injuries while also promoting mental health;
- (6) to promote UHC, defined as universal access to quality prevention, promotion, treatment, rehabilitation and palliation services and financial risk protection as fundamental to the health component in the post-2015 development agenda;
- (7) to emphasize the need for multisectoral actions to address social, environmental and economic determinants of health, to reduce health inequities and contribute to sustainable development, including Health in All Policies as appropriate;
- (8) to call for the full realization of the right to the enjoyment of the highest attainable standard of physical and mental health and to consider that this right is fundamental to equitable and inclusive sustainable development;
- (9) to recognize the importance of accountability through regular assessment of progress by strengthening of civil registration and vital statistics and health information systems with disaggregated data to monitor health equity;
- (10) to include health related indicators for measuring progress in all relevant dimensions of sustainable development;

¹ And, where applicable, regional economic integration organizations.

(11) to emphasize the importance of strengthening health systems, including the six building blocks of a health system (service delivery; health workforce; information; medical products, vaccines and technologies; financing; governance and leadership), to progress towards and sustain universal health coverage and improved health outcomes;

OP2 REQUESTS the Director-General:

- (1) to continue active engagement with ongoing discussions on the post-2015 development agenda, working with the United Nations Secretary-General, to ensure the centrality of health in all relevant processes;
- (2) to continue to inform Member States and provide support, upon request, on issues and processes concerning the positioning of health in the post-2015 development agenda.

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

1. Resolution	Health in the post-2015 development agenda
2. Linkage to the Programme budget 2014–2015 (see document A66/7 http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_7-en.pdf)	
Category: 4. Health systems	
<i>Also</i>	
Category: 1. Communicable diseases	Outcomes: Multiple
Category: 2. Noncommunicable diseases	Outputs: Multiple
Category: 3. Promoting health through the life course	
Programme areas: All in categories 1–4	
How would this resolution contribute to the achievement of the outcome(s) of the above programme area(s)?	
It would contribute to ensuring that people obtain the health services they need in all areas – whether for communicable or noncommunicable diseases – and across the life course. It supports the establishment of strong health systems, by acting on all their component parts – financing, health workforce, medical products, information, governance and infrastructure – in order to support the assurance of good-quality health services of all types, not just those for treatment, with financial risk protection. It encourages Member States to support the inclusion of health, including universal health coverage, in an appropriate form in the post-2015 development agenda. It will also encourage (i) the provision of information by the Secretariat to Member States, supporting them in developing their positions on health in the post-2015 development agenda, including by providing policy briefs and appropriate estimates; and (ii) the engagement of the Secretariat in the post-2015 process to support countries in ensuring that health is central to the agenda.	
Does the programme budget already include the outputs and deliverables requested in this resolution? (Yes/no)	
Yes.	
3. Estimated cost and staffing implications in relation to the Programme budget	
(a) Total cost	
Indicate (i) the lifespan of the resolution during which the Secretariat’s activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US\$ 10 000).	
(i)	Two years (covering the period 2014–2015)
(ii)	Total: US\$ 1.31 million (staff: US\$ 1.16 million; activities: US\$ 150 000)

(b) Cost for the biennium 2014–2015

Indicate how much of the cost indicated in 3(a) is for the biennium 2014–2015 (estimated to the nearest US\$ 10 000).

All the cost falls within the biennium 2014–2015.

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

The provision of support to countries in developing their strategies would cover all regions, with the Secretariat involved at all three levels of the Organization. The preparation of policy briefs and estimations would principally involve headquarters; there would also be some regional office involvement.

Is the estimated cost fully included within the approved Programme budget 2014–2015? (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.

4. Funding

Is the estimated cost for the biennium 2014–2015 indicated in 3 (b) fully funded? (Yes/no)

Yes.

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

Not applicable.

Dr SHAKEELA (Maldives) said that, although the report on monitoring the achievement of the health-related Millennium Development Goals (document A67/19) provided data on current status and trends, it was not clear to which Goals the reported results referred. Moreover, the indicators used to measure progress related to 1990 levels, and situations had changed since then. In addition, the generalized global indices, aggregates and benchmarks used did not take into account individual countries' vulnerabilities and situations. Data disassociated from geography would yield only a partial picture. For example, on the basis of the indicators for target 7.C under Goal 7, which related to improving access to water and sanitation, many countries in the South-East Asia Region could be considered to have attained that Goal, yet their water was contaminated and unsafe to drink.

Dr VIROJ TANGCHAROENSATHIEN (Thailand), speaking as chairman of the drafting group, reported long hours of intensive and constructive discussions which had led to consensus. He drew attention to two minor changes not reflected in the foregoing text: the word “all” should be deleted from the first line of the tenth preambular paragraph and “/AIDS” should be inserted after “HIV” in subparagraph 1(3). The text was balanced, and he encouraged the Committee to approve it.

Mr PARIRENYATWA (Zimbabwe), speaking on behalf of the Member States of the African Region, stressed that the outstanding elements of the Millennium Development Goals must be central to the post-2015 development agenda. Work on the Goals had highlighted the need to take a holistic approach to the improvement of health and to tackle social and economic determinants of health that lay outside the traditional areas of direct influence and action by the health sector. A multisectoral approach to the post-2015 development agenda would be essential to its success, and it should include additional priorities, including noncommunicable diseases, mental health and neglected tropical

diseases. Achieving universal health coverage would assist in the fulfilment of the original aspirations of primary health care, health for all and health systems strengthening enshrined in the Ouagadougou Declaration on Primary Health Care and Health Systems in Africa. The use of modern technology, particularly mobile phones, was one of the strategic ways that accessibility of health services could be ensured in Africa, even in remote areas.

The new development goals should be all-encompassing, the targets realistic and the indicators unambiguous and measurable, and health targets should be included under other relevant development goals. The post-2015 development agenda should be applicable to national contexts, respect national priorities and have a strong emphasis on country ownership. The Health Assembly should adopt a strong resolution, emphasizing the central role of health in the post-2015 development agenda so as to provide a clear mandate for those engaged in negotiations on the agenda.

Dr MAAROUFI (Morocco), speaking on behalf of the Member States of the Eastern Mediterranean Region, applauded the Secretariat's efforts to lower child mortality rates and maternal mortality ratios, improve nutrition and reduce morbidity and mortality due to HIV/AIDS. A plan to reduce infant and maternal mortality was being implemented in nine countries with support from UNFPA, WHO and other partners. Nevertheless, many countries in the Region would have difficulty in achieving the health-related Goals by 2015. Progress in preventing mother-to-child transmission of HIV was slow and the tuberculosis detection rate remained low mainly because the private sector was not obliged to notify cases.

Many of the countries lacked basic services while others had to safeguard hard-won gains in the context of water shortage, conflicts, non-sustainable consumption patterns and climate change. The risks to health as a result of accidents, natural disasters and hazards in general had to be mitigated. The prices, availability and affordability of medicines and vaccines must be monitored and support provided for implementing the WHO Guideline on Country Pharmaceutical Pricing Policies and for sustainable financing to essential medicines. A plan of action, with innovative and strong measures, was needed at the national and regional levels. The health targets were wide-ranging and he called for noncommunicable diseases to be included as a goal or target. The post-2015 development agenda must integrate universal health coverage and work on social determinants of health.

Dr AL-JALAHMA (Bahrain) said that the post-2015 development agenda should encompass work on Goals 4 and 5 to reduce child and maternal mortality and Goal 6 to cover HIV/AIDS, malaria, tuberculosis and other major diseases. The post-2015 goal should also cover noncommunicable diseases, road traffic accidents and mental health as well as universal health coverage, which was a *sine qua non*. She supported the draft resolution.

Dr ALMEIDA (Timor-Leste), speaking on behalf of the Member States of the South-East Asia Region, said that they had made significant progress towards the achievement of the Millennium Development Goals, but needed to continue their efforts in order to attain all the health-related Goals. She supported the draft resolution.

Dr KESKİNKILIÇ (Turkey)¹ said that work on the health-related Millennium Development Goals had improved the lives of people in developing countries, but much remained to be done, particularly with regard to providing physically and economically accessible health services to underserved populations. Universal health coverage should be one of the main health priorities in the post-2015 development agenda, with specific targets and activities on maternal and child health. Turkey had a decade of experience in providing all its citizens with equitable access to its health infrastructure and was willing to share that experience.

¹ At the invitation of the Chairman and in the interests of good timekeeping, this statement was not delivered in full at the meeting.

Mr EMANUELE (Ecuador), expressing support for the draft resolution, stressed that the activities requested of the Director-General in paragraph 2 should be undertaken in consultation with and with the knowledge of Member States, particularly with regard to the proposal of specific goals, targets and indicators.

Dr AMMAR (Lebanon) maintained that health would be high on the post-2015 development agenda and be seen as a pillar of sustainable social and economic development. The main challenge would be to align the health-related goals and targets proposed by the High-level Panel of Eminent Persons on the Post-2015 Development Agenda with the outcome of the thematic consultation on health in the post-2015 development agenda organized by WHO and UNICEF and to accommodate the recommendations of the regional committees. Sustaining efforts to achieve the Millennium Development Goals would be an important starting-point, and reducing the burden of noncommunicable diseases should be a priority. Universal health coverage should be emphasized as both a target and a means to achieve other targets. The text of the draft resolution was acceptable.

Mr AASLAND (Norway)¹ strongly supported the idea of a single aggregate health goal in the post-2015 development agenda, together with several ambitious and quantitative targets. Progress made with regard to the Millennium Development Goals must be consolidated and built upon, and the post-2015 targets must reflect the areas covered by the Goals. Substantive targets were needed in areas such as universal access to sexual and reproductive health, noncommunicable diseases, health systems strengthening and universal health coverage. The new development framework must also cover determinants of health, particularly with regard to education, energy, nutrition and food security, water and sanitation, gender equality, human rights, peace and conflict resolution, poverty eradication and governance.

Ms BRUNET (Canada) said that her country wished to sponsor the draft resolution. In order not to lose the gains achieved and to accelerate progress, maternal, newborn and child health had to remain at the heart of the post-2015 development agenda. Canada would imminently be hosting a high-level summit on maternal, newborn and child health (Toronto, 28–30 May 2014) to consider the progress made and the way forward, including the post-2015 development agenda.

Dr WALAIPORN PATCHARANARUMOL (Thailand) said that Thailand also wished to sponsor the draft resolution.

Ms RUIZ VARGAS (Mexico), speaking also on behalf of Argentina, Botswana, Denmark, Finland, Netherlands, Norway, Sweden and Switzerland, expressed support for the draft resolution. The focus on the post-2015 development agenda should not detract attention from efforts to achieve the Millennium Development Goals, particularly those on which the least progress had been made. The post-2015 agenda should have a human rights-based and life course approach and aim to ensure that people not only lived longer but also enjoyed the highest attainable standard of health and lived a dignified life. With health both a goal in itself and a means of accelerating development, the new development agenda should clarify the synergies between health and other objectives and should recognize the need for shared solutions and multisectoral action on social determinants of health.

Universal health coverage was essential to ensuring the accessibility, availability and affordability of high-quality health care services provided by well-trained personnel. Accelerating progress on the unmet Millennium Development Goals, reducing the burden of noncommunicable diseases, promoting healthy lifestyles and ensuring sexual and reproductive rights should be key elements in the post-2015 development agenda, with disease prevention and health promotion as

¹ At the invitation of the Chairman and in the interests of good timekeeping, this statement was not delivered in full at the meeting.

priorities. WHO should continue to take an active role in ensuring that health priorities were incorporated into the post-2015 development agenda.

Dr AL-TAAE (Iraq) underlined the importance of maintaining the progress made towards the achievement of the Millennium Development Goals. Other priorities included prevention and control of noncommunicable diseases, addressing the health impacts of mass gatherings, and health systems strengthening.

Ms BONNER (Germany) said that health, a basic human right and of vital importance for human development, should be part of the post-2015 development agenda. Universal health coverage should be the cornerstone of that agenda.

Dr EVANGELISTA (Philippines), noting that little time remained before the deadline for achievement of the Millennium Development Goals, said that health was central to development and growth. As such, it should receive priority funding from health ministries and in national budgets. She encouraged Member States to commit themselves to sustaining development efforts beyond 2015.

Mr KRANIAS (Greece),¹ speaking on behalf of the European Union and its Member States, the former Yugoslav Republic of Macedonia, Montenegro, Iceland, Serbia, Albania, Bosnia and Herzegovina, Ukraine, the Republic of Moldova, Armenia and Georgia, said that progress on the Millennium Development Goals needed to be accelerated; catalytic resources were required, together with investment in national systems, in order to sustain the gains made. Substantial progress was needed on maternal health, particularly with regard to sexual and reproductive health services for young people, and on maternal, infant and young child nutrition. In contrast, the number of deaths among children under five years of age had been substantially reduced. Further progress depended on successful implementation of agreed action plans, with monitoring and evaluation at the country level. Despite good progress towards Goal 6 (Combat HIV/AIDS, malaria and other diseases), the burden of HIV/AIDS, tuberculosis and malaria remained high and drug resistance was a growing challenge. Strong country ownership, inclusive leadership, gender equality, a person-centred and human rights-based approach and effective governance were key elements for achieving the Millennium Development Goals. In order to accelerate progress, more attention should be paid to other cross-cutting challenges, such as tackling the social, cultural, economic and environmental determinants of health, inequalities, gender imbalances and discrimination, and barriers to health services. He expressed support for the draft resolution.

Mr BOISNEL (France) stressed universal health coverage as an overarching objective for the global agenda; such an objective would make it possible to achieve the Millennium Development Goals and pay attention to new issues such as noncommunicable diseases. A cross-cutting approach was required, particularly regarding health systems strengthening.

Ms ALGOE (Suriname), speaking on behalf of the members of the Union of South American Nations, expressed support for the draft resolution.

Dr USHIO (Japan) expressed appreciation for the hard work of the drafting group and requested that Japan be named as a sponsor of the draft resolution.

Dr MSEMO (United Republic of Tanzania), welcoming the inclusion of the subject on the agenda of the Health Assembly, expressed support for the draft resolution.

¹ At the invitation of the Chairman and in the interests of good timekeeping, this statement was not delivered in full at the meeting.

Ms DOAN PHUONG THAO (Viet Nam), welcoming the progress made towards achievement of the Millennium Development Goals, said that the remaining gaps among and within countries and the need to provide more sustainable results posed challenges to the Secretariat and Member States. Current trends implied that programmes on acute respiratory infections needed to be re-established, as such infections remained the main cause of death among children in many countries. The report contained in document A67/19 had a narrow focus as it only concentrated on natural morbidity, child mortality and specific infectious diseases as factors affecting the achievement of the Millennium Development Goals. More attention was needed on other issues, including the different determinants of health. The monitoring of goals indirectly related to health, such as those on climate change and poverty, was also needed.

Dr ETALEB (Libya) expressed support for the draft resolution, even though it was not sufficiently realistic. A rational and sustained financing mechanism was needed to support programmes and provide good health services.

Ms Hsiang-Yi HSU (Chinese Taipei)¹ expressed support for the draft resolution. Chinese Taipei had made progress towards achievement of the Millennium Development Goals related to maternal, infant and young child care. It provided health education of women during pregnancy and there had been strong uptake of prenatal examinations, which had helped to reduce maternal and neonatal mortality rates. A life-course approach had been adopted to meet the health care needs of pregnant women and new mothers, and encouragement of and support for breastfeeding had resulted in high rates. Health should be regarded as a core element of sustainable development, and Chinese Taipei had recently merged its health and social welfare departments in order to enable the development of more comprehensive policies and holistic health care systems.

Mr DAWSON (World Vision International), speaking at the invitation of the CHAIRMAN, said that current measures of health and gaps in health information collected concealed inequalities in health care provision. Families and communities had an important role to play in the collection, review and analysis of data that related to their own health and lives. Good data were fundamental to efforts to tackle inequality but were often poor or non-existent in many countries. Member States should invest in and expand work towards universal effective coverage of health information, civil registration and vital statistics systems.

Mrs BAUMGARTEN (The Save the Children Fund), speaking at the invitation of the CHAIRMAN, called for faster progress on newborn survival and greater zeal to end preventable maternal, newborn and child deaths. To do so would need rectifying inequalities in service coverage and financial risk protection. Universal health coverage offered an integrated approach to service coverage without financial hardship, but universal must mean 100% coverage; any lower target ran the risk of institutionalizing inequities, which would undermine States' responsibilities to respect, protect and fulfil the human right to health.

Professor BEAGLEHOLE (World Heart Federation), speaking at the invitation of the CHAIRMAN, said that the post-2015 development agenda should include a universally applicable, overarching health goal focusing on maximizing healthy lives at all stages of life, with a stand-alone and ambitious target on noncommunicable diseases. Universal health coverage and social determinants of health should be recognized as essential elements of the post-2015 agenda; health indicators should also be integrated into all areas of that agenda.

¹ At the invitation of the Chairman and in the interests of good timekeeping, this statement was not delivered in full at the meeting.

Dr AHMED MOHAMED GAD (The World Medical Association, Inc.), speaking at the invitation of the CHAIRMAN, urged the inclusion both of the goal of health across all stages of life in the post-2015 framework and of targets on communicable and noncommunicable diseases, mental health, sexual and reproductive health, maternal and child health, neglected tropical diseases and social determinants of health. Universal health coverage should be acknowledged as a means of achieving health for all; to improve the health status of all people, it was vital to strengthen holistic health care systems and link them to social determinants of health. Development goals were interdependent, with health particularly important for the attainment of other goals; all development goals should include health-related indicators.

Mr NETTO (Medicus Mundi International – International Organisation for Cooperation in Health Care), speaking at the invitation of the CHAIRMAN, said that, although the proposals for the post-2015 development framework were based on equality and sustainability, global economic policies continued to contribute to widening inequalities. Development was more than economic growth and industrialization: it included social, cultural and institutional aspects. New economic relations and new forms of regulation were needed, based on the principles of equity, rights and *buen vivir*. The issue of universal health coverage was complicated by its multiple interpretations; it had different meanings to different interest groups.

Mr MUNZERT (International Federation of Medical Students' Associations), speaking at the invitation of the CHAIRMAN, said that achieving equity in health required the inclusion of all target groups of society based on their specific needs; indicators disaggregated by, inter alia, socioeconomic status, age, gender, and location were therefore vital. Health systems needed to be sustainable and adaptable to future risks and challenges. Given that the discussions on the post-2015 development agenda were being led by Member States' ministries of foreign affairs and permanent missions to the United Nations in New York, it was vital that health ministries provided information to those representatives on the importance of including health in the post-2015 framework.

The CHAIRMAN took it that the Committee wished to approve the draft resolution, as amended by the Chairman of the drafting group during the meeting.

The draft resolution, as amended, was approved.¹

Dr MORALES OJEDA (Cuba), speaking in his capacity as President of the World Health Assembly, welcomed the approval of the draft resolution and encouraged Member States to work as efficiently as possible to ensure that the agenda could be completed on time.

The DIRECTOR-GENERAL explained that Member States had been endeavouring to work as efficiently as possible, with many of them submitting statements in writing in order to save time. She assured those delegates that their submissions would be published on the WHO website.

Addressing the global challenge of violence, in particular against women and girls: Item 14.3 of the Agenda (Document A67/22) (continued from the first meeting, section 3)

The CHAIRMAN drew attention to a draft resolution proposed by the delegations of Albania, Australia, Belgium, Canada, Guatemala, India, Italy, Latvia, Mexico, Namibia, Netherlands, Norway, Paraguay, Portugal, Republic of Moldova, Switzerland, Thailand, Turkey, Ukraine, Uruguay, United States of America and Zambia, which read:

¹ Transmitted to the Health Assembly in the Committee's sixth report and adopted as resolution WHA67.14.

The Sixty-seventh World Health Assembly,

PP1 Having considered the report on addressing the global challenge of violence, in particular against women and girls;¹

PP2 Recalling resolution WHA49.25 (1996), which declared violence a leading worldwide public health problem, resolution WHA56.24 (2003) on implementing the recommendations of the *World report on violence and health*, and resolution WHA61.16 (2008) on the elimination of female genital mutilation;

PP3 Cognizant of the many efforts across the United Nations system to address the challenge of violence, in particular against women and girls, and against children including the International Conference on Population and Development, the Beijing Declaration and Platform for Action, and all relevant United Nations General Assembly and Human Rights Council resolutions, as well as all relevant Commission on the Status of Women agreed conclusions;

PP4 Noting that violence is defined by the WHO as “the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation”;²

PP5 Noting also that interpersonal violence, distinguished from self-inflicted violence and collective violence, is divided into family and intimate partner violence and community violence, and includes forms of violence throughout the life course, such as child abuse, intimate partner violence, abuse of the elderly, family members, youth violence, random acts of violence, rape or sexual assault and violence in institutional settings such as schools, workplaces, prisons and nursing homes;³

PP6 Recalling the definition of violence against women as stated in the 1993 Declaration on the Elimination of Violence against Women A/RES 48/104;

PP7 Concerned that the health and wellbeing of millions of individuals and families is adversely affected by violence and that many cases go unreported;

PP8 Further concerned that violence has health-related consequences including death, disability and physical injuries, mental health impacts and sexual and reproductive health consequences, as well as social consequences;

PP9 Recognizing that health systems often are not adequately addressing the problem of violence and contributing to a comprehensive multisectoral response;

PP10 Deeply concerned that globally, one in three women experience either physical and/or sexual violence, including by their spouses, at least once in their lives;⁴

PP11 Concerned that violence, in particular against women and girls, is often exacerbated in situations of humanitarian emergencies and post-conflict settings, and recognizing that national health systems have an important role to play in responding to its consequences;

PP12 Noting that preventing interpersonal violence against children – boys and girls – can contribute significantly to preventing interpersonal violence against women and girls and children, that being abused and neglected during infancy and childhood makes it more likely that people will grow up to perpetrate violence against women, maltreat their own children, and engage in youth violence, and underscoring that there is good evidence for the effectiveness of parenting support programmes in preventing child abuse and neglect in order to halt the intergenerational perpetuation of interpersonal violence;

¹ Document A67/22.

² World report on violence and health. Geneva: World Health Organization; 2002.

³ Page 6 of World report on violence and health. Geneva: World Health Organization; 2002.

⁴ Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence. WHO, 2013.

PP13 Noting also that violence against girls needs specific attention because they are subjected to forms of violence related to gender inequality that too often remain hidden and unrecognized by society, including by health providers, and while child abuse (physical, emotional) and neglect affects boys and girls equally, girls suffer more sexual violence;

PP14 Deeply concerned that violence against women during pregnancy has grave consequences on the health of both the woman and the pregnancy, such as miscarriage and premature labour, and for the baby such as low birth weight, as well as recognizing the opportunity that antenatal care provides for early identification, and prevention of the recurrence of such violence;

PP15 Concerned that children, particularly in child-headed households, are vulnerable to violence, including physical, sexual and emotional violence, such as bullying, and reaffirming the need to take action across sectors to promote the safety, support, protection, health care and empowerment of children, especially girls in child-headed households;

PP16 Recognizing that boys and young men are among those most affected by interpersonal violence, which contributes greatly to the global burden of premature death, injury and disability, particularly for young men, and has a serious and long-lasting impact on a person's psychological and social functioning;

PP17 Deeply concerned that interpersonal violence, in particular against women and girls, and children, persists in every country in the world as a major global challenge to public health, and is a pervasive violation of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health and a major impediment to achieving gender equality, and has negative socioeconomic consequences;

PP18 Recognizing that violence against women and girls is a form of discrimination, that power imbalances and structural inequality between men and women are among its root causes, and that effectively addressing violence against women and girls requires action at all levels of government including by the health system, as well as the engagement of civil society, the involvement of men and boys and the adoption and implementation of multifaceted and comprehensive approaches that promote gender equality and empowerment of women and girls and that change harmful attitudes, customs, practices and stereotypes;

PP19 Aware that the process under way for the post-2015 development agenda may, in principle, contribute to addressing, from a health perspective, the health consequences of violence, in particular against women and girls, and children, through a comprehensive and multisectoral response;

PP20 Acknowledging also the many regional, subregional and national efforts aimed at coordinating prevention and response by health systems, to violence, in particular against women and girls and against children;

PP21 Noting with great appreciation the leading role WHO has played in establishing the evidence base on the magnitude, risk and protective factors,¹ consequences, prevention of and response to violence,² in particular against women and girls,³ and against children, in the

¹ Protective factors are those that decrease or buffer against the risk and impact of violence. While much of the research on violence against women and violence against children has focused on risk factors, it is important for prevention also to understand protective factors. Prevention strategies and programmes aim to decrease risk factors and/or to enhance protective factors.

² Including the World Report on Violence and Health (2002).

³ Including the WHO Multi-country Study on Women's Health and Domestic Violence against Women (2005); Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence (2013); Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines (2013).

development of norms and standards, in advocacy and in supporting efforts to strengthen research, prevention programmes and services for those affected by violence;¹

PP22 Also noting that addressing violence, in particular against women and girls and against children is included within the leadership priorities of WHO's Twelfth General Programme of Work 2014–2019 in particular to address the social, economic and environmental determinants of health;

PP23 Recognizing the need to scale up interpersonal violence prevention policies and programmes to which the health system contributes and that while some evidence-based guidance exists on effective interventions, more research and evaluation of these and other interventions is required;

PP24 Stressing the importance of preventing interpersonal violence before it begins or reoccurs, and noting that the role of the health system in the prevention of violence, in particular against women and girls, and against children, includes supporting efforts to: reduce child maltreatment, such as through parenting support programmes; address substance abuse including the harmful use of alcohol; prevent the reoccurrence of violence by providing health and psychosocial care and/or rehabilitation for victims and perpetrators and to those who have witnessed violence; and, collect and disseminate evidence on the effectiveness of prevention and response interventions;

PP25 Affirming the health system's role in advocating, as an element of prevention, for interventions to combat the social acceptability and tolerance of interpersonal violence, in particular against women and girls, and against children, emphasizing the role such advocacy can play in promoting societal transformation;

PP26 Recognizing that interpersonal violence, in particular against women and girls, and against children, can occur within the health system itself, which can negatively impact the health workforce, the quality of health care provided and lead to disrespect and abuse of patients, and discrimination to access of services provided;

PP27 Affirming the important and specific role that national health systems must play in identifying and documenting incidents of violence, and providing clinical care and appropriate referrals for those affected by such incidents, particularly women and girls, and children, as well as contributing to prevention and advocating within governments and among all stakeholders for an effective, comprehensive, multisectorial response to violence,

OP1. URGES Member States:²

(OP1.1) to strengthen the role of their health systems in addressing violence, in particular against women and girls, and against children, to ensure that all people at risk and or affected by violence have timely, effective, and affordable access to health services, including health promotion, curative, rehabilitation and support services that are free of abuse, disrespect and discrimination, to strengthen their contribution to prevention programmes and to support WHO's work related to this resolution;

(OP1.2) to ensure health system engagement with other sectors, such as education, justice, social services, women's affairs, and child development, in order to promote and develop an effective, comprehensive, national multisectorial response to interpersonal violence, in particular against women and girls, and against children, by, inter alia, adequately addressing violence in health and development plans, establishing and adequately financing national multisectorial strategies on violence prevention and

¹ This work is carried out mainly by the Department of Violence and Injury Prevention and Disability, the Department of Reproductive Health and Research, the Department for Mental Health and Substance Dependence and the Department for Emergency Risk Management and Humanitarian Response, in close collaboration with Regional and Country Offices.

² And, where applicable, regional economic integration organizations.

response including protection, as well as promoting inclusive participation of relevant stakeholders;

(OP1.3) to strengthen their health system's contribution to ending the acceptability and tolerance of all forms of violence against women and girls, including through advocacy, counselling and data collection, while promoting the age-appropriate engagement of men and boys alongside women and girls, as agents of change, in their family and community, so as to promote gender equality and the empowerment of women and girls;

(OP1.4) to strengthen the national response, in particular the national health system response, by improving the collection and, as appropriate, dissemination of comparable data disaggregated for sex, age, and other relevant factors, on the magnitude, risk and, protective factors, types, and health consequences of violence, in particular against women and girls, and against children, as well as information on best practices, including the quality of care and effective prevention and response strategies;

(OP1.5) to continue to strengthen the role of their health systems so as to contribute to the multisectoral efforts in addressing interpersonal violence, in particular against women and girls, and against children, including by the promotion and protection of human rights, as they relate to health outcomes;

(OP1.6) to provide access to health services, as appropriate, including in the area of sexual and reproductive health;

(OP1.7) to seek to prevent reoccurrence and break the cycle of interpersonal violence, by strengthening, as appropriate, the timely access for victims, perpetrators and those affected by interpersonal violence to effective health, social and psychological services and to evaluate such programmes to assess their effectiveness in reducing reoccurrence of interpersonal violence;

(OP1.8) to enhance capacities, including through appropriate continuous training of all public and private professionals from health and non-health sectors, as well as caregivers and community health workers, to provide care and support, as well as other related preventive and health promotion services to victims and those affected by violence, in particular women and girls and children;

(OP1.9) to promote, establish, support and strengthen standard operating procedures targeted to identify violence against women and girls, and against children, taking into account the important role of the health system in providing care and making referrals to support services;

OP2. REQUESTS the Director-General:

(OP2.1) to develop, with the full participation of Member States,¹ and in consultation with United Nations organizations, and other relevant stakeholders focusing on the role of the health system, as appropriate, a draft global plan of action to strengthen the role of the health system within a national multisectoral response to address interpersonal violence in particular against women and girls and against children, building on existing relevant WHO work;

(OP2.2) to continue to strengthen WHO efforts to develop the scientific evidence on the magnitude, trends, health consequences and risk and protective factors for violence, in particular against women and girls and against children, and update the data on a regular basis, taking into account Member States input, and to collect information on best practices, including the quality of care and effective prevention and response strategies in order to develop effective national health systems prevention and response;

(OP2.3) to continue to support Member States, upon their request, by providing technical assistance for strengthening the role of the health system, including in sexual and

¹ And, where applicable, regional economic integration organizations.

reproductive health, in addressing violence, in particular against women and girls, and against children;

(OP2.4) to report to the Executive Board at its 136th session on progress implementing this resolution, and on the finalization in 2014 of a global status report on violence and health which is being developed in cooperation with UNDP and UNODC, and reflects national violence prevention efforts, and to report also to the Executive Board at its 138th session on progress in implementing this resolution, including presentation of the draft global action plan, for consideration by the Sixty-ninth World Health Assembly.

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

1. Resolution: Strengthening the role of the health system in addressing violence, [in particular] against women and girls									
2. Linkage to the Programme budget 2014–2015 (see document A66/7 http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_7-en.pdf) Category: 2. Noncommunicable diseases <table> <tr> <td>Programme area: Violence and injuries</td><td>Outcome: 2.3 Output: 2.3.3</td></tr> <tr> <td>Programme area: Mental health and substance abuse</td><td>Outcome: 2.2 Output: 2.2.2</td></tr> </table> Category: 3. Promoting health through the life course <table> <tr> <td>Programme area: Reproductive, maternal, newborn, child and adolescent health</td><td>Outcome: 3.1 Output: 3.1.4</td></tr> </table> Category: 5. Preparedness, surveillance and response <table> <tr> <td>Programme area: Emergency risk and crisis management</td><td>Outcome: 5.3 Output: 5.3.1</td></tr> </table>		Programme area: Violence and injuries	Outcome: 2.3 Output: 2.3.3	Programme area: Mental health and substance abuse	Outcome: 2.2 Output: 2.2.2	Programme area: Reproductive, maternal, newborn, child and adolescent health	Outcome: 3.1 Output: 3.1.4	Programme area: Emergency risk and crisis management	Outcome: 5.3 Output: 5.3.1
Programme area: Violence and injuries	Outcome: 2.3 Output: 2.3.3								
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Programme area: Reproductive, maternal, newborn, child and adolescent health	Outcome: 3.1 Output: 3.1.4								
Programme area: Emergency risk and crisis management	Outcome: 5.3 Output: 5.3.1								
How would this resolution contribute to the achievement of the outcome(s) of the above programme area(s)? The resolution would contribute to bringing increased attention to bear on violence, in particular violence against women and girls, as a public health issue, on its severe health impacts and its preventability, and on the role that the health sector plays in tackling violence. It would further strengthen the health sector's role within a multisectoral response and provide committed policy-makers in the health sector with a stronger mandate for dealing with the topic. The resolution would also help to increase collaboration both between WHO and its external partners and within the Organization.									
Does the programme budget already include the outputs and deliverables requested in this resolution? (Yes/no) Yes.									

3. Estimated cost and staffing implications in relation to the Programme budget**(a) Total cost**

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

(i) Five years (covering the period 2014–2018)

(ii) Total: US\$ 34.65 million (staff: US\$ 18.81 million; activities: US\$ 15.84 million)

(b) Cost for the biennium 2014–2015

Indicate how much of the cost indicated in 3(a) is for the biennium 2014–2015 (estimated to the nearest US\$ 10 000).

Total: US\$ 13.54 million (staff: US\$ 7.39 million; activities: US\$ 6.15 million)

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

All levels of the Organization.

Is the estimated cost fully included within the approved Programme budget 2014–2015? (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, for the biennium 2014–2015.

For the biennium 2016–2017 and beyond, additional staff might be needed, in particular at regional and country levels.

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.

The need for additional staff will depend on the development of the global plan of action requested in the resolution.

4. Funding

Is the estimated cost for the biennium 2014–2015 indicated in 3 (b) fully funded? (Yes/no)

No: approximately US\$ 5 million of the US\$ 13.54 million for the biennium have currently been secured.

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

For the biennium 2014–2015, the funding gap is approximately US\$ 8.54 million. It is envisaged that the gap will be closed through the financial dialogue process and coordinated resource mobilization efforts.

He reminded the Committee that a drafting group had been established to discuss the draft resolution and agree on a consensus text.

Dr MAKASA (Zambia), speaking in his capacity as co-chair of the drafting group, said that the drafting group had convened for a total of eight sessions and had agreed on a consensus text. He expressed appreciation for the active participation of and flexibility and spirit of compromise shown by Member States during the deliberations. It was clear that strengthening the role of the health system in addressing violence, particularly violence against women, girls and children in general, was of the utmost importance to all Member States.

Mr McIFF (United States of America), speaking in his capacity as co-chair of the drafting group, paid tribute to Member States for their resilience and their willingness to think creatively in order to achieve consensus and focus international attention on such an important issue. Once the resolution was adopted by the Health Assembly, the hard work of implementation would begin; among the next steps was the formulation by the Secretariat of a draft plan of action to address interpersonal violence. He hoped that the Committee would be able to approve the draft resolution as presented.

Ms HARB (Lebanon) said that as women and children were particularly affected by different forms of violence and abuse, they should be specifically targeted in relevant social and public health programmes, which should include activities such as addressing risk factors and providing medical care (including psychological and social support) and rehabilitation. Multisectoral collaboration was vital and should include a formal framework for the early involvement of law enforcement authorities. Health systems needed to be strengthened in order for them to provide medical and psychological assistance to victims of violence; notify law enforcement; and report to the Ministry of Health. A social network would be a useful tool for referral and follow-up activities. She highlighted the difficult situation of countries experiencing armed conflict, in which violence, including sexual abuse, against women and children was often exacerbated and health workers were often victims of violence.

Dr BASHEIR (Sudan), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that during the deliberations of the drafting group, the importance had been recognized of removing sensitive wording that might hinder universal acceptance and prevent the implementation of the draft resolution: it had been agreed to remove the phrase “intimate partner” from the draft resolution and replace it with “spouse”. However, although it had been removed from the tenth preambular paragraph, the phrase remained in the fifth preambular paragraph. The phrase should be removed and replaced with “spouse” as previously agreed. In addition, the paragraph should end with the words “forms of violence throughout the life course” and the remainder of the paragraph should be deleted.

Dr REDDY (India) said that the Secretariat’s report rightly emphasized the importance of multisectoral action on the issue. He encouraged Member States to support the draft resolution and to undertake concerted efforts to develop a comprehensive and multisectoral response and strengthen the role of health systems in addressing violence. He looked forward to working in close collaboration with WHO and relevant organizations of the United Nations system on such an important agenda item.

Mr CANDIA (Paraguay) stressed the importance of the draft resolution, which had been discussed in an extremely detailed and responsible way by the group of sponsors and by the Member States during consultations before and during the current Health Assembly. Violence against women and girls was a worrying reality and no one, much less WHO, could be indifferent to the search for an appropriate solution to the situations faced by women and girls around the world. He urged Member States to approve the draft resolution.

Dr KIBACHIO (Kenya) said that violence, particularly against women, girls and children in general was an important public health issue; Kenya therefore wished to be named as a sponsor of the draft resolution with its original wording, as the phrase referred to by the delegate of Sudan was intended to differentiate between hidden forms of violence within families and within the broader community.

Dr EVANGELISTA (Philippines), welcoming the timely discussion of the issue given the recent abduction by armed men of more than 300 schoolgirls in Nigeria, said that violence against women and children was a problem for all countries; far-reaching preventive actions were needed in all sectors and at all levels to tackle the issue. Particular attention should be paid to violence against

sex workers, girls without parents or mothers, children of migrant workers, adolescent girls and trafficked women. More emphasis should also be placed on the importance of educating and empowering both men and women to create a society free of gender-based violence. Addressing the social determinants of gender-based violence and building societies that upheld women's rights and inclusion were crucial, and health systems should play a supporting role in that regard.

Dr KARRER (Switzerland) said that countering violence in all its forms, particularly against women, girls and children in general, was of great importance for his country. The issue should be approached from the point of view of its impact on victims and their families, without making any distinction about the nature of the perpetrator or the circumstances of and reasons behind such attacks. No progress could be achieved on the issue without achieving gender equality. Therefore any potential approach had to be based on human rights. The draft resolution had a number of merits, but many Member States had had to make concessions; the role of the health system in treating violence in situations of conflict and other humanitarian crises would have been worthy of inclusion in the operative paragraphs of the resolution, in order to consolidate the gains made on the issue within the United Nations system. He commended the collective efforts by Member States to make progress on the issue.

Ms PADILLA RODRÍGUEZ (Mexico) said that her country was committed to participating actively in drawing up an action plan. Violence was an alarmingly prevalent global public health issue with a variety of causes, particularly intolerance, inequity and impunity. Girls and women were more vulnerable to sexual violence, but boys were at high risk of suffering from physical violence and reproducing that violence later in life. Member States should take steps to ensure that all forms of violence and ill-treatment were not tolerated for any reason and to give due consideration to the short-, medium- and long-term consequences of violence. Efforts should also be made to scale up effective preventive interventions.

Professor HALTON (Australia) asked whether, in the spirit of compromise, the wording of the fifth preambular paragraph could be left as it was, with an explanatory footnote to address the concerns expressed by the delegate of Sudan.

Dr AL-JALAHMA (Bahrain) suggested that the word "intimate" could be removed from the fifth preambular paragraph; the act of violence was the key issue, not whether the perpetrator was an intimate partner or not.

Mr ALSAATI (Saudi Arabia) said that his country strongly condemned violence in all its forms; the difficulty with the term "intimate partner" was that it did not apply to his country's societal norms, in which there were only marital partners and no other type of intimate relationship. It had been agreed in the drafting group to remove the term from the entire draft resolution.

Dr EL-REFAY (Egypt) said that the phrase "intimate partner" was a term used solely by the Secretariat and was not United Nations-agreed terminology. It therefore created difficulties for Member States if it were used in a formal document such as a resolution. He expressed support for the proposals made by the delegates of Bahrain and Sudan.

Dr MAKASA (Zambia), speaking in his capacity as co-chair of the drafting group, expressed agreement with the suggestion to remove the word "intimate".

Dr AL-TAAE (Iraq), welcoming the suggestion made by the delegate of Bahrain regarding removal of the word "intimate", said that in the first preambular paragraph and the first and third lines of the eighteenth preambular paragraph, the words "and children" should be inserted after "women and girls". In addition, "and/or emotional" should be inserted after "physical" in the fourth preambular

paragraph. The words “sexual and” should be deleted from the phrase “sexual and reproductive health” in the eighth preambular paragraph and in subparagraphs (OP1.6) and (OP2.3); they were unnecessary, as the concept was covered by the term “reproductive”. In the sixteenth preambular paragraph, “boys” should be replaced by “children”.

Mr McIFF (United States of America), speaking in his capacity as co-chair of the drafting group and supported by Mr RUSH (United Kingdom of Great Britain and Northern Ireland) and Mr RIETVELD (Netherlands), agreed that the term “intimate” could be deleted, as proposed by the delegate of Bahrain.

Dr ELOAKLEY (Libya) expressing support for the proposal made by the co-chairs of the drafting group and the delegate of Bahrain, observed that during the present Health Assembly, there had been a large number of different meetings running concurrently and often for long periods of time; such an approach should not be encouraged in future.

Mr AASLAND (Norway) said that although he supported the proposal made by the co-chairs of the drafting group and the delegate of Bahrain, he would prefer to retain the wording originally agreed; there should not be further substantive discussion of the draft resolution.

Mr KLEIMAN (Brazil) supported the proposal by the delegate of the United States of America; Member States could not continue to ignore the issue of violence against girls, women and children.

The DIRECTOR-GENERAL explained that she had held informal consultations with the delegate of Iraq, who had agreed to withdraw his amendments. She expressed sincere thanks to the delegate for his flexibility.

Dr AL-TAAE (Iraq) said that it was important that the draft resolution was approved; he was therefore happy to withdraw all of his amendments. He supported the proposal made by the delegate of Bahrain.

Dr NYIKAL (Kenya) asked whether it was still intended to include the words “and children” in the first preambular paragraph and to retain the word “boys” in the sixteenth preambular paragraph.

The DIRECTOR-GENERAL said that it should be possible to include that phrase and retain that word.

Mr KLEIMAN (Brazil) said that the wording of the first preambular paragraph quoted the title of the report by the Secretariat contained in document A67/22; it would therefore be strange to insert additional wording.

Mrs PENIĆ IVANKO (Croatia) requested that Croatia be named as a sponsor of the draft resolution.

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

The draft resolution, as amended, was approved.¹

¹ Transmitted to the Health Assembly in the Committee's sixth report and adopted as resolution WHA67.15.

8. PREPAREDNESS, SURVEILLANCE AND RESPONSE: Item 16 of the Agenda (resumed)**Smallpox eradication: destruction of variola virus stocks:** Item 16.3 of the Agenda (Document A67/37)

Ms GURBANOVA (Azerbaijan) said that the reports referred to in document A67/37 contained a number of divergent recommendations. Moreover, the conclusions of the advisory bodies were not unanimous, and the issue required further detailed consideration. It was essential that WHO undertook rigorous inspections of the containment facilities at the repositories in the Russian Federation and the United States of America to ensure compliance with biosafety and biosecurity standards.

Mr LEWIS (Canada)¹ said that he accepted the findings of the WHO Advisory Committee on Variola Virus Research and the Advisory Group of Independent Experts. The remaining stocks of variola virus should be destroyed when it could be definitively established that they were no longer required for public health research purposes and proliferation concerns had been resolved. Canada was not ready to take a decision on setting a date for destruction since further work was required, particularly with respect to synthetic biology, for which his country would be pleased to make technical experts available.

Dr GWINJI (Zimbabwe) drew attention to the conclusion of the Advisory Group of Independent Experts that there was no need, from a global health perspective, to retain live variola virus for any further research. He would not support the establishment of an expert group or any extension or expansion of the research programme. Recalling the existence of WHO recommendations concerning the distribution, handling and synthesis of variola virus DNA and drawing attention to resolution WHA60.1 in which the Health Assembly had requested the Director-General to ensure that any research undertaken did not involve genetic engineering of the variola virus, he asked for a date to be set for destruction of the virus stocks.

Mr AGAFONOV (Russian Federation) said that the majority view of the WHO Advisory Committee on Variola Virus Research at its fifteenth meeting, that live variola virus was needed for the further development of antiviral agents against smallpox, was consistent with decision WHA64(11) reaffirming the need to reach consensus on a proposed new date for destruction for the variola virus stocks, when research outcomes crucial to an improved public health response to an outbreak so permitted. The Russian Federation was willing to participate in the continued work on an operational framework for access to WHO's emergency stockpile of smallpox vaccines in response to a smallpox event, and considered that a similar mechanism should be developed for stockpiles of smallpox medication. The WHO Advisory Committee on Variola Virus Research was fully competent to evaluate the potential impact of new technologies on smallpox preparedness and countermeasures. All Member States should have equitable access to all medication and, as the host of one of the two variola virus repositories, the Russian Federation was working towards that goal.

Mr KOLKER (United States of America) said that his country supported the retention of variola virus stocks until sufficient countermeasures against smallpox had been developed. Recalling that advances in synthetic biology had made it increasingly possible to recreate variola, he strongly endorsed the conclusion of the Executive Board at its 134th session that the Director-General should organize a group of experts to review advances in gene synthesis technology, in particular whether the variola virus could be created synthetically and whether additional research on countermeasures should be considered. Having noted that such a step was fully in accordance with resolution

¹ At the invitation of the Chairman and in the interests of good timekeeping, this statement was not delivered in full at the meeting.

WHA60.1, he said that the United States was committed to making the benefits of the research as widely available as possible.

Ms GAILIUTE (Lithuania)¹ welcomed the recommendation of the Strategic Advisory Group of Experts on immunization and paid tribute to the ongoing work of the WHO biosafety teams. However, rapidly advancing technologies gave rise to concerns that complex viruses could be recreated without the need for seed stocks. Those new risks dictated the need to consider the adequacy of existing countermeasures. Since more than 40% of the world's population had not been vaccinated against smallpox, there were significant risks in the event of an outbreak of the disease. She agreed with other speakers that it might therefore be premature to set a date for the destruction of smallpox virus stocks at the current Health Assembly, and considered that preparedness offered the best solution for the elimination of smallpox risks.

Dr ELOAKLEY (Libya), speaking on behalf of the Member States of the Eastern Mediterranean Region, noted that the WHO Advisory Committee had concluded that there was no need to retain variola virus stocks for further diagnostics for smallpox or for the development of safer vaccines. The Strategic Advisory Group of Experts on immunization had made recommendations on the vaccine stockpile, addressing outbreak control requirements and the protection of laboratory workers, among other matters. For that reason, the Member States of the Region considered that the variola stocks had already served their purpose in terms of global and public health, and that their maintenance was a concern in terms of possible laboratory accidents. He urged the Director-General to take all necessary measures to establish a deadline for the destruction of those stocks, in line with decision WHA64(11).

Dr DAHN (Liberia), speaking on behalf of the Member States of the African Region, drew attention to the conclusion of the Advisory Group of Independent Experts and said that the destruction of the live variola virus was in the best interests of the global community. Noting with satisfaction that the WHO biosafety inspection teams had visited the two variola virus repositories in 2012 and had confirmed that the research therein was being done safely and securely, she said that a timeline should be set for the two repositories to reduce their research, in stages defined by percentages and under the supervision of WHO biosafety teams, in order to arrive at dates for final destruction of the live virus.

Dr GAMKRELIDZE (Georgia), having commended the work of the advisory groups, expressed support for the position expressed by the delegate of the United States of America and would welcome the organization of a group of experts to study new evidence for and against a decision on the destruction of variola virus stocks. Live strains must be maintained under the control of WHO until the final decision was taken.

Dr BUGTI (Pakistan) recalled the conclusion of the Advisory Group of Independent Experts that there was no public health reason for continued retention of the virus. Noting that WHO had stringent rules on the distribution, handling and synthesis of variola virus DNA, which could effectively control any risks related to biotechnology, she said that a date should be set for destruction of virus stocks.

Dr REN Minghui (China) agreed that the live variola virus should no longer be used in research. He proposed starting the process of destruction and strictly banning synthesis of the variola virus. The Secretariat should inform Member States of variola research findings, and he encouraged exchanges of experience with respect to diagnosis, treatment and vaccines. The WHO Advisory Committee on Variola Virus Research should provide support to developing countries.

¹ At the invitation of the Chairman and in the interests of good timekeeping, this statement was not delivered in full at the meeting.

Dr REDDY (India), noting the conclusion of the Advisory Group of Independent Experts and the majority view of the WHO Advisory Committee on Variola Virus Research, said that there were no serious technical obstacles to setting a date for destruction of variola virus stocks under the supervision of the Director-General. India was not convinced about the passive new threats from smallpox. Recalling resolution WHA60.1, he did not support the formation of any group of experts to study the implications of technologies for biological synthesis and their potential impact on smallpox preparedness.

Mr CORRALES HIDALGO (Panama) expressed support for the establishment of a group of experts that could agree on rules for moving forward, and agreed that WHO should continue to provide assurances that existing stocks were kept in appropriate conditions.

Mr LUTNÆS (Norway), noting the recommendations from the advisory groups, said that the technology for synthetic production of the smallpox virus existed. A laboratory-produced virus could potentially have the same capacities as the original virus. More information was needed about the implications of that development for public health preparedness against potential future outbreaks. He therefore supported the proposal to organize a group of experts to provide an up-to-date assessment of those technologies and their potential impact on smallpox preparedness, as had also been agreed by the Executive Board at its 134th session.

Dr Y. PILLAY (South Africa) said that he was pleased to confirm that the destruction and disposal of the remaining cloned variola virus DNA fragments in South Africa had been completed in January 2014 under the observation of WHO. The international community should be working towards the establishment of clear timelines for the destruction of remaining stocks.

Mr KIM Ganglip (Republic of Korea) said that his country recognized bioterrorism as a national threat and remained concerned about the development of recreated complex viruses. Given the possibility of a threat to health security that could not be addressed appropriately through the use of existing vaccines, he called for further research and discussion through a group of experts. Caution should be exercised in taking the decision on the destruction of virus stocks, in the light of the need to safeguard global health and security.

Dr EVANGELISTA (Philippines) applauded the outcomes of the fifteenth meeting of the WHO Advisory Committee on Variola Virus Research. In the light of the report contained in document A67/37, he recommended that a reasonable timeline should be provided for the destruction of all remaining variola virus stocks once all essential public health research had been completed; that the Health Assembly should reaffirm its decision not to authorize variola virus research not essential to public health; and that countries should be kept updated on the progress of research and be involved in the development of the laboratory network for smallpox as part of the WHO Emerging and Dangerous Pathogens Laboratory Network.

Mr PIPPO (Argentina)¹ said that he did not oppose maintaining virus collections at the two WHO Collaborating Centres for further research on diagnostics, vaccines and antiviral agents. He agreed with the recommendations of the Strategic Advisory Group of Experts on immunization concerning donations to and the current size of the WHO vaccine stockpile. Discussions with national regulatory agencies of donating countries on establishing a regulatory framework for the donation of smallpox vaccine should continue. He expressed support for the Secretariat's proposal to convene a

¹ At the invitation of the Chairman and in the interests of good timekeeping, this statement was not delivered in full at the meeting.

group of experts to provide an up-to-date assessment of the relevant technologies and their potential impact on smallpox preparedness.

Mr FERDINAN TARIGAN (Indonesia) said that WHO should take a leading role in maintaining a stockpile of vaccines and antiviral medicines, and arrange outbreak response guidelines that would include the operational framework for access to such a stockpile. In the light of the conclusion of the Advisory Group of Independent Experts to review the smallpox research programme, to the effect that there was no need to retain stocks of variola virus, Indonesia supported WHO's efforts to foster agreement among Member States on the final destruction of the remaining variola virus stocks.

Dr USHIO (Japan) recalled that the ultimate goal of smallpox eradication was the destruction of the remaining laboratory virus stocks. However, in view of threats to international health security, such as bioterrorism, the time was not yet right for destruction. Discussions should continue on vaccine stocks and research and development, with an appropriate time frame established. He supported the Secretariat's proposal to convene a group of experts.

Dr ELENWUNE (Nigeria),¹ noting that destruction of the official stocks would not prevent rogue countries or organizations from retaining their own, said that authorized stocks of variola virus should be retained until appropriate countermeasures had been put in place to respond to a potential smallpox outbreak.

Dr TAKIAN (Islamic Republic of Iran), recalling decision WHA64(11), by which the Health Assembly had strongly reaffirmed its previous decisions that the remaining stocks of variola virus should be destroyed, observed that none of the three separate deadlines that it had set had been met. All necessary research with live variola virus had been completed, and any further studies would have only limited public impact and delay destruction further. The Health Assembly should exercise its leadership and decide on the destruction of the remaining stocks of live variola virus at an early date; terminate authorization of research involving live variola virus; ensure universal and equitable ownership of the achievements of all previous research activities, including antiviral agents, vaccines and diagnostic tools; prohibit genetic engineering of the variola virus; and put in place strict, transparent and accountable oversight mechanisms, in particular for the destruction of existing stocks.

Ms LANTERI (Monaco) called on the Secretariat to convene a group of experts to review technologies for advances in biosynthesis technology in the near future, noting that the conclusions of that group would facilitate the setting of a date for destruction.

Mr KLEIMAN (Brazil), emphasizing the importance of smallpox preparedness, said that it would be premature to set a date for destruction of virus stocks, which were under WHO's supervision and would be an asset in further research. He would support the convening of a group of experts to consider issues including biological synthesis of the virus.

Dr MANAMOLELA (Lesotho) said that she would support the convening of a group of experts to review recent scientific advances in gene synthesis technology with a view to preventing the re-emergence of smallpox.

Mr RUSH (United Kingdom of Great Britain and Northern Ireland) endorsed the views expressed by the delegate of the United States of America on delaying destruction of the virus stocks,

¹ At the invitation of the Chairman and in the interests of good timekeeping, this statement was not delivered in full at the meeting.

noted that the international scientific community was not fully aligned on the evidence, and supported convening a group of experts to consider the risks of synthetic creation of the virus and the potential need for more research.

Ms RUIZ VARGAS (Mexico) agreed with others that it would be in the public health interest to retain a stock of variola virus for use in research, noting the potential danger of biological and bacteriological threats to human security in the 21st century.

Ms Li-Ying LAI (Chinese Taipei) expressed support for resolution WHA60.1. In 2011, Chinese Taipei had developed a mass vaccination programme to respond to a potential outbreak; it had sufficient quantity of the first-generation vaccine to cover its population and had procured a small amount of the third-generation vaccine despite the high cost.

Mrs DE TROEYER (Medicus Mundi International – International Organisation for Cooperation in Health Care), speaking at the invitation of the CHAIRMAN, called on the Health Assembly to set an early and irrevocable date for the destruction of smallpox virus stocks. All elements of the WHO authorized research programme requiring smallpox virus had been completed, and the Organization's own experts had concluded that there was no public health reason for the continued retention of stocks. The case for retaining the virus appeared to rest on the risk of unauthorized or unforeseen release of the virus, but the remaining stocks were held at WHO-authorized repositories. Their continued existence presented a real and significant risk in terms of laboratory biosafety and security. Their immediate destruction was the single most effective means of ensuring that the smallpox virus would not reappear, either accidentally or deliberately.

The DIRECTOR-GENERAL noted that Member States were divided on whether to destroy existing stocks of variola virus. Her understanding of the discussion was that there was agreement that the stocks should, ultimately, be destroyed. However, some Member States felt that more work was needed to find safe countermeasures to smallpox before destruction was undertaken, while others urged that a destruction date be set quite soon. Even the experts on the WHO Advisory Committee on Variola Virus Research were not unanimous on the need for further research.

She had heard no destruction date mentioned, however, and therefore supposed that the discussion would continue. In the meantime, the Secretariat would enhance its understanding of the underlying biological issues, on which the scientific community was divided, by consulting with independent scientific opinions worldwide and with the regional directors and, as requested by some speakers, would maintain the two stockpiles in the United States of America and the Russian Federation, ensuring biosafety and biosecurity. She asked the Member States to agree to the convening of a geographically representative, gender-balanced group of people from different fields of expertise to advise her on the advantages and disadvantages of the technology and the science, so that she could in turn advise the Member States.

It was so decided.

The CHAIRMAN invited the Committee to note the report.

The Committee noted the report.

9. PROGRESS REPORTS – Item 17 of the Agenda (Document A67/40)

Mr BOISNEL (France) said that, as certain Executive Board functions had been transferred to the Health Assembly, it was a shame that the progress reports were unable to be addressed in a comprehensive manner. He called on all Member States and the Secretariat to ensure that they received due attention during the next Health Assembly.

Mr VEGA MOLINA (Spain) agreed with the delegate of France that sufficient time had to be set aside for the examination of progress reports and regretted that such had not been the case.

Communicable diseases**A. Global health sector strategy on HIV/AIDS, 2011–2015 (resolution WHA64.14)**

Dr Y. PILLAY (South Africa)¹ noted global progress in combating HIV/AIDS but said that much remained to be done, particularly in sub-Saharan Africa. In South Africa, which had the largest burden of people living with HIV, 2.5 million people were now receiving antiretroviral therapy, but it was important to ensure that significant drug resistance did not develop. He called on WHO to reduce the prices of third-line antiretroviral medicines; work with partners to develop better paediatric formulations; and begin drafting the next global health sector strategy for HIV/AIDS, taking into account the global strategy for tuberculosis, and the global strategy for human resources that was being drawn up.

Ms VALLINI (Brazil) supported the comment made by the delegate of South Africa, reiterating the need for transparent discussions on a new global health sector strategy for HIV/AIDS, to be ready for approval by Member States in 2015.

Mr USTINOV (Russian Federation)¹ said that the number of HIV tests carried out each year in the Russian Federation was one of the highest in the world, and the number of people receiving antiretroviral treatment would increase with the implementation of new clinical guidelines and treatment eligibility criteria. Vertical transmission had been almost eradicated, and the Russian Federation was willing to share its experience in that regard. He supported WHO's "Treatment as Prevention" strategy and coordinated efforts to reduce the cost of antiretroviral medicines worldwide. The number of HIV-positive people in the Russian Federation did not confirm earlier expert predictions of an epidemic.

The primary cause of HIV infection in the Russian Federation and the former Soviet Union was intravenous drug use; the country's medical profession was of the unanimous view that the best way to solve the problem was to ban the use of all illegal drugs. In terms of rehabilitation, drug-dependent patients (including, recently, those in Crimea and Sebastopol) were offered various treatments, including antiretroviral drugs and opioid antagonists. Russian nongovernmental organizations had played a positive role in rehabilitation after drug replacement therapy.

Ms BONNER (Germany) joined the delegates of South Africa and Brazil in calling for the development of a follow-up strategy on HIV/AIDS, as the current global health sector strategy on HIV/AIDS was due to come to an end in 2015.

Mr McIFF (United States of America) welcomed the mid-term review of the global health sector strategy on HIV/AIDS. WHO had a leadership role to play in achieving an AIDS-free

¹ At the invitation of the Chairman and in the interests of good timekeeping, this statement was not delivered in full at the meeting.

generation and control of the HIV epidemic, providing normative guidance based on science and innovation. WHO must continue to prioritize its work on HIV and ensure that regional efforts were targeted, effective and results-based.

Mr SOSSOU (Benin),¹ speaking on behalf of the Member States of the African Region, noted with satisfaction the progress made in implementing the global health sector strategy on HIV/AIDS, 2011–2015. With the technical and financial support of their partners, the Region's governments had considerably reduced the number of new infections across the Region, improved access to antiretroviral drugs, reduced the number of AIDS-related deaths and curbed the mother-to-child transmission rate. However, the continent's excessive dependence on international donors and funding compromised the sustainability of the action it took to fight the disease. In order to fight HIV/AIDS, the Region's Member States had to give effect to the Abuja commitment and allocate 15% of the State budget to the health sector and promote innovative health funding mechanisms. Strengthening public–private partnerships was a strategic component of domestic funding for HIV/AIDS activities. At the first meeting of African ministers of health, convened jointly by WHO and the African Union Commission (Luanda, April 2014), the need had been recognized to establish the African Medicines Agency, which would promote the subregional production of medicines and inputs and reorganize drug supply systems. He appealed to the international community to support that initiative.

Mr VEGA MOLINA (Spain)¹ said that, in line with the WHO global health sector strategy on HIV/AIDS, 2011–2015 and the UNAIDS Reaching Zero strategy, Spain had adopted a plan to prevent and control HIV infection that was based on scientific knowledge, best practices and innovation, and was directed in particular at the most vulnerable groups. The plan constituted the common core for action by all administrations and governmental and nongovernmental organizations responding to the epidemic. It was predicated, *inter alia*, on a coordinated response to the epidemic, early diagnosis and prevention of the associated disabilities and comorbidities, improved access to early treatment, follow-up and continued care, guaranteed equality of access and non-discrimination of persons living with HIV.

Ms Li-Ying LAI (Chinese Taipei) said that Chinese Taipei was facing a growing HIV epidemic among men who had sex with men, primarily as a result of using recreational drugs. She called on WHO to provide guidance on how to prevent and control the use of recreational drugs among young people, so as to reduce transmission of HIV.

B. Eradication of dracunculiasis (resolution WHA64.16)

Noncommunicable diseases

C. Child injury prevention (resolution WHA64.27)

Promoting health through the life course

D. Reproductive health: strategy to accelerate progress towards the attainment of international development goals and targets (resolution WHA57.12)

Dr SHAKEELA (Maldives), speaking on behalf of Australia, Belgium, Botswana, Brazil, Bulgaria, Denmark, Ecuador, Estonia, Finland, France, Ghana, Germany, Iceland, Latvia, Lithuania, Luxembourg, Mexico, Monaco, Nepal, Netherlands, New Zealand, Norway, Portugal, Slovenia, South Africa, Spain, Sweden, Switzerland, Thailand, Tunisia, United Kingdom of Great Britain and Northern

¹ At the invitation of the Chairman and in the interests of good timekeeping, this statement was not delivered in full at the meeting.

Ireland, Uruguay and Zambia, said that the Programme of Action from the International Conference on Population and Development recognized the importance of reproductive rights and was the cornerstone of WHO's reproductive health strategy. While some progress had been made on sexual and reproductive health and rights, attainment of Millennium Development Goal 5 (Improve maternal health) remained a challenge, and implementation of WHO's strategy at global, regional and national levels was crucial. Improving sexual and reproductive health and rights would contribute to attaining gender equality, eradicating poverty and achieving sustainable development and universal health coverage. The areas requiring more attention had been rightly identified in the progress report, and there was a particular need to reach all people, particularly those in marginalized situations.

E. Female genital mutilation (resolution WHA61.16)

Ms ANDERSSON (Sweden),¹ speaking on behalf of the Nordic countries, Denmark, Finland, Iceland, Norway and Sweden, welcomed plans to focus on research and guidelines and to scale up treatment and rehabilitation for girls and women who had undergone female genital mutilation. WHO should ensure adequate resources to support health workers and implement resolution WHA61.16 and United Nations General Assembly resolution 67/146. Female genital mutilation must remain high on global and national health agendas.

F. Youth and health risks (resolution WHA64.28)

Mr McIFF (United States of America) emphasized that people of all ages should be involved in discussions and decisions about their own health. For that reason, a youth representative had been part of his national delegation for the first time, and he encouraged other delegations to adopt that practice.

Mr OSEI (Ghana),¹ speaking on behalf of the Member States of the African Region, welcomed continued efforts to promote the health of young people. The health sector should play a leading role in multisectoral approaches to adolescent health, and several youth-focused national policies and strategies had been developed in the Region. However, the coordination of activities related to the health of young people remained inadequate, and the lack of financial and human resources had affected the provision of support to Member States. He encouraged the Secretariat to redouble efforts to mobilize the funds required to promote the health of young people.

G. Implementation of the recommendations of the United Nations Commission on Life-Saving Commodities for Women and Children (resolution WHA66.7)

Ms ANDERSSON (Sweden),¹ speaking on behalf of the Nordic countries, Denmark, Finland, Iceland, Norway and Sweden and recalling resolution WHA66.7, commended the progress made by the eight pathfinder countries, technical partners and the Reproductive, Maternal, Newborn and Child Health Trust Fund. Member States were encouraged to strengthen the implementation of initiatives to overcome barriers to accessing essential reproductive, maternal, newborn and child health commodities.

H. Climate change and health (resolution EB124.R5)

Mr VEGA MOLINA (Spain)¹ encouraged WHO to pursue its efforts to include the present and future challenges related to climate change and health on the list of global public health priorities. The only way to ensure greater resilience and promote health sector adaptation to climate change was to

¹ At the invitation of the Chairman and in the interests of good timekeeping, this statement was not delivered in full at the meeting.

prepare health systems to detect, reduce, prevent and respond to the effects of climate change on health observed in various parts of the world.

Ms ANDERSSON (Sweden),¹ speaking on behalf of the Nordic countries, Denmark, Finland, Iceland, Norway and Sweden, noted that the WHO work plan on climate change and health had expired and should be renewed, particularly in the light of the Conference on Health and Climate, which was to take place in August 2014. Recalling WHO's contribution to the Climate and Clean Air Coalition, she said a draft resolution on air pollution and health would be submitted to the Sixty-eighth World Health Assembly, and the matter should be a priority for the Organization.

Health systems

I. Global strategy and plan of action on public health, innovation and intellectual property (resolution WHA61.21)

Mrs NAARENDORP (Suriname) recalled that the global strategy and plan of action on public health, innovation and intellectual property envisaged the award of prizes to incentivize innovation and the delinkage of costs. However, as the update on the global strategy did not provide any information in that regard, she requested clarification from the Secretariat.

J. Availability, safety and quality of blood products (resolution WHA63.12)

K. Human organ and tissue transplantation (resolution WHA63.22)

Mr VEGA MOLINA (Spain) said that the increasingly widespread use in clinical practice of medical products of human origin (including cells, tissue and organs, blood and breast milk) called for a shift in focus. All were donated and therefore exposed to the same risks. The WHO Guiding Principles on Human Cell, Tissue and Organ Transplantation should be applied to such products in view of their origin, their non-commercial nature and the need to establish traceability mechanisms. He therefore welcomed the Secretariat's special initiative on medical products of human origin and asked that it continue to be developed.

Mr PIPPO (Argentina) emphasized the non-commercial nature of medical products of human origin and supported the statement made by the delegate of Spain in that regard.

L. WHO strategy on research for health

Preparedness, surveillance and response

M. WHO's response, and role as the health cluster lead, in meeting the growing demands of health in humanitarian emergencies (resolution WHA65.20)

Mrs LAMPRIANOU (Greece),¹ speaking on behalf of the Member States of the European Union, said that Turkey, 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.

She welcomed the enhancement of WHO's preparedness and surge capacity at all organizational levels and encouraged the Secretariat to ensure that its internal procedures, including temporary

¹ At the invitation of the Chairman and in the interests of good timekeeping, this statement was not delivered in full at the meeting.

recruitment, would guarantee rapid responses. She also welcomed WHO's efforts under the Transformative Agenda of the Inter-Agency Standing Committee, which had been implemented in recent and current crisis situations. Enhanced cluster coordination would result in targeted, prioritized and swift delivery of aid. Performance of the Global Health Cluster should be further strengthened, seeking continuity of humanitarian actions and long-term development. The Secretariat was encouraged to cooperate further with the International Committee of the Red Cross on the Health Care in Danger project, as violent acts against health care personnel were increasing in conflict-driven emergencies. In view of the increasing funding gap, voluntary donations would be required to support WHO's Emergency Response Framework, and she requested updated information on humanitarian funds received by WHO.

Dr LAHTINEN (Finland) commended the progress made in implementing resolution WHA65.20 and the increased recognition of WHO's central role by Member States. Sufficient capacity was required to enable WHO to respond to humanitarian crises in an effective, efficient and timely manner, for which Member States should allocate adequate core funding.

Dr CARTIER (Belgium)¹ recognized the growing trend of increased and often deliberate violence against health care workers and users in humanitarian crises and expressed concern regarding its dramatic consequences, including short-term limitations of access to services and long-term impacts on health. That was a violation of international humanitarian law. Fifty Member States had signed a joint declaration during the Syrian Humanitarian Forum, which recalled countries' obligations under the Geneva Conventions; another declaration signed by 27 Member States called for all parties involved in the conflict to protect civilians and medical personnel and infrastructure. He supported the Health Care in Danger project and welcomed WHO's collaboration. All Member States should respond to the recommendations issued from that project and ensure that health care professionals and service users were protected, in the Syrian Arab Republic and around the world.

Corporate services/enabling functions

N. Multilingualism: implementation of action plan (resolution WHA61.12)

Mr BOISNEL (France),¹ speaking on behalf of the countries that were members or observers of the Organisation Internationale de la Francophonie, emphasized the importance of multilingualism, thanked the Secretariat for its implementation of the corresponding action plan, and recalled that multilingualism should be fully included in the WHO reform process. He asked how the appointment of a coordinator for multilingualism would be translated into specific action within the various departments of the Organization. The Secretariat should collaborate with other organizations of the United Nations system to share good practices and seek out synergies. The increase in multilingual content on the website was to be welcomed, although there was a persistent disparity between the number of pages uploaded in English and in WHO's other official languages, in particular on the financing dialogue web portal and in social media. He welcomed the free language training made available to staff members and drew attention to the importance of multilingualism in the recruitment process. Statistics on the fluency of professional staff members in the official languages should be made available, as called for in resolution WHA61.12.

Mr VEGA MOLINA (Spain)¹ acknowledged the Secretariat's efforts to increase the multilingual content of the WHO website. The point was not merely to reduce the gap between the amount of content in English and other languages, but rather to treat all official languages equally. For

¹ At the invitation of the Chairman and in the interests of good timekeeping, this statement was not delivered in full at the meeting.

Member States, the section of the website on the Organization's financing and, in particular, the portal on the financing dialogue were key components that should be available in the official languages. Documents could be translated in time if they were published in advance.

Multilingualism was a fundamental principle of the work of the United Nations and its staff selection and recruitment processes. It was unacceptable for meetings to be continued without interpretation. Whenever possible, Secretariat staff should make presentations in the various official languages and all delegates should use interpretation services when available. The *Grupo de Apoyo al Español* (Spanish Support Group), launched several months earlier by several Member States, hoped to work closely with WHO.

Dr NDIAYE (Senegal), speaking on behalf of the Member States of the African Region, welcomed the increases in multilingual content on the WHO website and in WHO's Institutional Repository for Information Sharing; the authorization of almost 400 translations in 49 languages; and the free language training offered to staff members.

The CHAIRMAN urged delegates to read the statements provided by nongovernmental organizations under the agenda item, which were available on the WHO website, as time would not allow them to be read out at the current meeting.

The Committee noted the progress reports.

10. SIXTH REPORT OF COMMITTEE A (Document A67/72)

Dr MBUGUA (Kenya), Rapporteur, read out the draft sixth report of Committee A.

The report was adopted.¹

11. CLOSURE OF THE MEETING

After the customary exchange of courtesies, the CHAIRMAN declared the work of Committee A completed.

The meeting rose at 20:40.

¹ See page 348.

COMMITTEE B

FIRST MEETING

Wednesday, 21 May 2014, at 14:40

Chairman: Dr R. RUGUNDA (Uganda)

1. OPENING OF THE COMMITTEE: Item 18 of the Agenda

The CHAIRMAN welcomed participants and Dr Baye Lukong (Cameroon) who, as Vice-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 twentieth meeting (Geneva, 14–16 May 2014).

Election of Vice-Chairmen and Rapporteur

The CHAIRMAN informed the Committee that Dr Mohsen Asadi-Lari (Islamic Republic of Iran) and Dr Siale Akauola (Tonga) had been nominated as Vice-Chairmen and Dr Dipendra Raman Singh (Nepal) as Rapporteur.

Decision: Committee B elected Dr Mohsen Asadi-Lari (Islamic Republic of Iran) and Dr Siale Akauola (Tonga) as Vice-Chairmen, and Dr Dipendra Raman Singh (Nepal) as Rapporteur.¹

2. ORGANIZATION OF WORK

The CHAIRMAN said that the agenda items allocated to the Committee would be dealt with in the order in which they appeared in the agenda (document A67/1 Rev.1) and appealed to speakers to limit the length of their statements to three minutes. As at previous meetings, timing would be indicated by a traffic-light system.

It was so agreed.

3. HEALTH CONDITIONS IN THE OCCUPIED PALESTINIAN TERRITORY, INCLUDING EAST JERUSALEM, AND IN THE OCCUPIED SYRIAN GOLAN: Item 19 of the Agenda (Documents A67/41, A67/INF./2, A67/INF./3, A67/INF./4 and A67/INF./5)

The CHAIRMAN drew attention to a draft decision proposed by the delegations of Algeria, Egypt, Iraq, Jordan, Kuwait, Libya, Morocco, Oman, Palestine, Tunisia, United Arab Emirates and Yemen, which read:

¹ Decision WHA67(5).

The Sixty-seventh World Health Assembly,

Mindful of the basic principle established in the Constitution of the World Health Organization, which affirms that the health of all peoples is fundamental to the attainment of peace and security, and stressing that unimpeded access to health care is a crucial component of the right to health,

REQUESTS the Director-General:

(1) to report on the health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan, to the Sixty-eighth World Health Assembly, based on a field assessment, including with special focus on:

(a) barriers to health access in the occupied Palestinian territory, as well as progress made in the implementation of the recommendations contained in the World Health Organization 2013 report on “Right to health: barriers to health access in the occupied Palestinian territory”;

(b) access to adequate health services on the part of Palestinian prisoners;

(c) the effect of prolonged occupation and human rights violations on mental health, particularly the mental consequences of the Israeli military detention system on child detainees;

(d) the effect of impeded access to water and sanitation, as well as food insecurity, on health conditions in the occupied Palestinian territory, particularly in the Gaza Strip;

(e) the provision of financial and technical assistance and support by the international donor community, and its contribution to improving health conditions in the occupied Palestinian territory;

(2) to provide support to the Palestinian health services, including capacity building programmes;

(3) to provide health-related technical assistance to the Syrian population in the occupied Syrian Golan;

(4) to continue providing necessary technical assistance in order to meet the health needs of the Palestinian people, including prisoners and detainees in cooperation with the efforts of the International Committee of the Red Cross, and the handicapped and injured;

(5) to also provide support to the Palestinian health sector in preparing for emergency situations, and scale up emergency preparedness and response capacities;

(6) to support the development of the health system in the occupied Palestinian territory, including development of human resources.

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

<p>1. Decision Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan</p>
<p>2. Linkage to the Programme budget 2014–2015 (see document A66/7 http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_7-en.pdf)</p> <p>Categories: All</p> <p>Programme areas: The decision links to programme areas in all the categories. Outcomes: All Outputs: All</p> <p>How would this decision contribute to the achievement of the outcome(s) of the above programme area(s)?</p> <p>The six actions requested in the decision and the comprehensive work of the Organization that this involves would contribute to all the programmatic outcomes.</p>

Does the programme budget already include the outputs and deliverables requested in this decision? (Yes/no)

Yes, with the exception of the field assessment and subsequent annual report, which are outside the scope of the Programme budget 2014–2015.

3. Estimated cost and staffing implications in relation to the Programme budget**(a) Total cost**

Indicate (i) the lifespan of the decision 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) One year (from May 2014 to May 2015)

(ii) Total: US\$ 4.79 million (staff: US\$ 2.83 million; activities: US\$ 1.96 million)

(b) Cost for the biennium 2014–2015

Indicate how much of the cost indicated in 3(a) is for the biennium 2014–2015 (estimated to the nearest US\$ 10 000).

All the cost falls within the biennium 2014–2015.

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

The costs would be incurred predominately at the country level, with some technical support for the field assessment and the related report potentially provided by the Regional Office for the Eastern Mediterranean and headquarters.

Is the estimated cost fully included within the approved Programme budget 2014–2015? (Yes/no)

No.

If “no”, indicate how much is not included.

US\$ 150 000, representing the cost of the field assessment and related report. The costs are currently not foreseen in the Programme budget 2014–2015; however, in view of the relatively small additional budget for the activities, the matter will be resolved through some reprogramming at country or regional level.

(c) Staffing implications

Could the decision 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 2014–2015 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\$ 803 500; this funding gap will be tackled as part of the Organization-wide coordinated resource mobilization plan for making good funding shortfalls in the Programme budget 2014–2015.

Dr ABDELNASSER (Egypt), introducing the draft decision, expressed concern at the various obstacles to access to health services described in the Secretariat's report (document A67/41) and at its inability to gain access to the occupied Syrian Golan and therefore to report on the health conditions there. The draft decision was consistent with the health goals set out in the WHO Constitution and with the basic principle that the health of all peoples was fundamental to the attainment of peace and

security. It therefore concerned one of the Organization's essential endeavours in the pursuit of its mandate: to ensure the provision of health services to the Palestinian people in the occupied Palestinian territory and to the Syrian people in the occupied Syrian Golan in order to prevent any further deterioration of the health situation. The delegations sponsoring the draft decision had sought through informal consultations to achieve the greatest possible consensus among the Member States of the Organization. He therefore hoped that the draft decision would be adopted by acclamation but, should that not be the case, he would call for its adoption by a roll-call vote in accordance with the provisions of Rules 72 and 73 of the Rules of Procedure of the World Health Assembly. The Health Assembly should send a strong message to the international community that the right to health was a right guaranteed to all peoples and that the global humanitarian conscience could not accept that peoples living under occupation were being denied full access to high-quality health services.

Mr ÇARIKÇI (Turkey) said that his country wished to cosponsor the draft decision. As described in the Secretariat's report, the people in the occupied territories continued to live in very poor conditions. Universal values and human conscience required every member of the international community to reject the illegal practices and restrictions on the Palestinian people that undermined their fundamental rights and freedoms, including the right to health. The main health concerns continued to stem from avoidable and preventable causes closely associated with the occupation, particularly the restrictions imposed on people's movements. The efforts of WHO and other United Nations organizations to alleviate the sufferings of the Palestinian people were to be commended; however, the results of that work were unsatisfactory because of the extraordinary conditions prevailing in the occupied territories. WHO also deserved praise for its advocacy work aimed at ensuring access to health care for Palestinian prisoners held in Israeli jails. The plight of the Palestinians in the Gaza Strip was also cause for concern. Turkey had delivered humanitarian aid, including fuel and medicine, to critical centres such as hospitals and water and sanitation facilities, but long-term solutions were urgently needed in order to avoid greater humanitarian risks. Affirming 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 invited all Member States to support the draft decision.

Mr MANOR (Israel) stressed his country's forceful rejection of the yearly ritual of introducing a politicized resolution or decision into the heavy agenda of the Health Assembly. He noted with satisfaction that WHO continued to provide considerable support to the Palestinian Ministry of Health and emphasized that Israel and WHO had the same interest: to enable medical and humanitarian aid to reach people in need. Israel had sent emergency medical aid to Gaza and enabled patients to be transferred from Gaza to Israeli hospitals. It worked closely with the Palestinian Ministry of Health to respond to the medical needs of the Palestinian population in the West Bank. Many Palestinian doctors and nurses attended training courses in Israel.

In the light of a recent joint statement by the heads of humanitarian agencies, including the Director-General of WHO, which had highlighted the appalling health and humanitarian situation in Syria, it was unbelievable that the draft decision should call for health-related assistance for inhabitants of the Golan Heights, where the health situation was, in fact, excellent. He requested a vote on the draft decision and called on delegates to vote against it and to reject the inclusion of the item in future Health Assembly agendas.

Mr KILANI (Tunisia) condemned the ongoing restrictions on people's movements in the Palestinian territory, the blockade on the Gaza Strip, the checkpoints, the travel permit regime and the barriers within the West Bank, all of which were imposed on the Palestinian people by the occupation forces and prevented them from accessing health care. His delegation welcomed WHO's support of the Palestinian Ministry of Health and of its efforts to modernize its infrastructure and build local capacity in the areas of quality management, facility safety and infection prevention; strengthen mental health care; raise public awareness of the dangers of tobacco use; and understand the

epidemiology of HIV/AIDS. WHO's contribution towards the establishment of a Palestinian National Institute of Public Health was also appreciated. He called on the Secretariat to intensify its support for the Palestinian people and urged all Member States to join Tunisia in supporting the draft decision, without reservation.

Mr MESBAH (Algeria), speaking on behalf of the Member States of the African Region, expressed concern at the health situation in the occupied Palestinian territory, including east Jerusalem, and the occupied Syrian Golan, affirming that the right to health of all peoples was fundamental to the attainment of peace and security. That situation had been aggravated by deteriorating social and economic conditions and the humanitarian crisis resulting from continuing occupation and the serious restrictions imposed, including the blockade on Gaza. He considered the situation to be a serious obstacle to the attainment of the right to health and called for checkpoints to be opened to allow the free circulation of people and goods and to enable the Palestinian Ministry of Health to ensure that health services functioned effectively and that the Palestinian people had access to preventive and curative health services and essential medicines. In that regard, he recalled the various resolutions and decisions adopted by the African Union. He also wished to draw attention to the living and health conditions of Palestinian prisoners, especially women and children, which he considered to be violations of international human rights law, particularly the conventions on the rights of women and children. It was urgent to resolve the health crisis in the occupied territory. To that end, the necessary support should be provided through international organizations for health services and emergency humanitarian aid. He supported the draft decision.

Mr MULREAN (United States of America) said that although the draft decision represented a changed approach from the draft resolutions proposed in previous years, it was not consistent with the shared objective of a World Health Assembly focused purely on public health that refrained from singling out countries on a political basis. By inviting the Director-General to prepare a report for the Sixty-eighth World Health Assembly, it would perpetuate consideration of a politicized agenda item. Furthermore, it would not lead to improved health among Palestinians or help to make peace between Israelis and Palestinians. His Government remained concerned about conditions in the area, particularly in Gaza, and would continue to work with Israel, the Palestinians and others to advance the needs of the Palestinian people through its development assistance programmes. It was the largest donor to UNRWA and would continue to support the Agency's work. He supported the delegate of Israel's call for a vote and his delegation would vote against the adoption of the draft decision.

Dr KHRAISHI (Palestine) expressed thanks for the support provided by WHO and many others to the Palestinian health sector and to UNRWA, which provided much assistance to the Palestinian people, who had endured 66 years of suffering at the hands of the occupying power. The delegate of Israel had stated that his Government had allowed a number of Palestinians to receive treatment, but people should not have to be granted permission to exercise the right to receive care, which was an absolute, natural right enshrined in the WHO Constitution and numerous declarations. As the supreme body responsible for global health, WHO had a responsibility to report on the disastrous health situation of the Palestinian people. As the International Committee of the Red Cross would confirm, over 120 Palestinian detainees had died in Israeli prisons owing to inadequate medical care, and more than 1200 were in poor health after spending more than 20 years in those prisons. The Israeli barriers in place prevented the transfer of patients to health facilities or for treatment abroad, as a result of which people had died and women had been forced to give birth at checkpoints, as had been documented by various United Nations bodies. Those barriers also prevented the delivery of medical supplies, some of which perished as a result. Again, it should not be a matter of "allowing" the entry of medical supplies, access to which was another absolute right.

It was the collective responsibility of Member States to rescue Palestinians from oppression and reckless killing, such as the incident on 15 March 2014 in which two Palestinians had been shot by Israeli forces. The situation was untenable. All Member States must therefore work with Palestine to

ensure Israel's compliance with its obligations as a full member of the international community and of WHO. Adoption of the draft decision would ensure that Member States were informed of the situation in a professional manner with a view to its discussion by the Sixty-eighth World Health Assembly.

Mr AHMAD (Pakistan) said that his Government was deeply concerned at the deteriorating health situation in the occupied Palestinian territory, particularly the restrictions on movement of patients, health personnel and materials and their consequences, and the general deterioration of health infrastructure and therefore health sector performance in the Gaza Strip as a result of the blockade. He appreciated the technical support, information and other services that WHO had provided to the Palestinian people in the occupied territory, but more needed to be done to avert a fast-developing health emergency. The scope of WHO's technical support to UNRWA needed to be enhanced, and it was important for WHO to exert its influence on donors in order to ease the funding crisis that had a direct and adverse impact on the health of innocent civilians, including women and children. A strong message had to be sent by the Health Assembly, an assembly of healers from around the world, calling for an end to the economic and political repression that continued to jeopardize access to preventive and curative health services by the people in the occupied territory. He fully supported the draft decision and urged the international community to support the people in the occupied territories.

Mrs FERNÁNDEZ-PALACIOS (Cuba) observed that the Government of Israel was continuing its aggressive policies against the Palestinian territory and the Syrian Golan. Provocative acts, attacks on the Gaza Strip and continued building of illegal settlements in east Jerusalem were clear demonstrations of its failure to respect the will of the international community. Those acts and the restrictions on movement, particularly around east Jerusalem, were exacerbating the deteriorating health situation and must cease immediately. The blockade on the Gaza Strip should be totally lifted. Israel's actions, which Cuba condemned in the strongest terms, had severely limited access to health care and hindered Palestine's progress towards achieving the Millennium Development Goals. Israeli occupation of the Syrian Golan continued to undermine the human rights of the inhabitants, particularly the right to health, which was a clear violation of Israel's obligations as the occupying power. Israel should comply with the relevant resolutions of WHO and the United Nations Security Council, General Assembly and Human Rights Council and withdraw from the occupied Syrian Golan. Cuba reaffirmed its unequivocal support for the Palestinian people in their legitimate aspiration to establish a free, independent and sovereign Palestinian State on the basis of the pre-1967 borders, with East Jerusalem as its capital. Cuba also stood in solidarity with the Syrian people and other Arab peoples threatened by Israel.

Dr ELHEMMALI (Libya), highlighting a number of facts contained in the Secretariat's report, noted that the blockade on the Gaza Strip and the presence of checkpoints and barriers within the West Bank prevented over 400 000 Palestinians from accessing health care and that out-of-pocket spending accounted for 40% of health expenditure, leading to the impoverishment of Palestinian families already living in extremely difficult economic circumstances. He called on all Member States believing in the human right to health to join his delegation in supporting the draft decision.

Dr DELGADO (Bolivarian Republic of Venezuela) affirmed his delegation's support for the draft decision, which accurately reflected the difficult situation in the occupied Palestinian territory. That situation had been exacerbated by the blockade and violent acts by Israel, the occupying power. The Venezuelan people condemned those acts unequivocally. He urged unanimous support for the draft decision in the interests of upholding the right to health and access to health care of the people in the occupied Palestinian territory, including east Jerusalem, and the occupied Syrian Golan.

Dr AL-NAYEF (Syrian Arab Republic) outlined his Government's position as set out in document A67/INF./3. Referring to the statement by the delegate of Israel, he said that Israel was one of the most racist States in the world and had no right to say anything about the situation in the Syrian

Arab Republic. In the previous year alone, the Government of the Syrian Arab Republic had provided numerous health services to over nine million Syrians. However, it needed support for the construction of hospitals and other medical facilities. The suffering of the Syrian people should not be ignored because of the immoral practices of the Israeli authorities in the occupied Syrian Golan. He called for WHO's support in putting an end to those practices. An independent field mission should be dispatched to assess the situation in the occupied Syrian Golan.

Dr AL SAIDI (Oman), expressing support for the draft decision, said that he shared the growing disquiet over the worsening economic and health situation in the occupied Palestinian territories, the crisis produced by the continuing occupation, and the severe restrictions imposed on the Palestinian people. The occupying power must comply with the advisory opinion given by the International Court of Justice in 2004 concerning the separation wall, which gravely affected access for Palestinians living in those territories to good quality medical services. It must likewise comply with the Geneva Convention of 1949 relative to the Protection of Civilian Persons in Time of War, which covered health workers and was applicable in the occupied Palestinian territories, including east Jerusalem, and in the occupied Syrian Golan. WHO and all stakeholders should intensify their efforts to ensure the delivery of essential health care to Palestinians detained in Israeli prisons, particularly children, women and the sick, whose health situation was a matter of grave concern.

Mr AL-SHEHABI (Bahrain) expressed deep concern over the severely compromised ability of the Palestinian Ministry of Health to function. The continuing political instability, financial crisis and unpredictability of funding jeopardized Palestine's health system and also placed vulnerable populations at risk. The Ministry of Health needed sustained high-level technical support in order to build a functioning health system. He called on WHO to provide capacity-building support to the Palestinian health services and technical support to facilitate the movement of drugs, equipment, medical teams and relief workers and to meet the health needs of the Palestinian people and the Syrian population in the occupied Syrian Golan. He also called for support to enable the Palestinian health sector to prepare for emergency situations and scale up emergency preparedness and response capacities. He urged all Member States to join Bahrain supporting the draft decision.

Dr AL HIYASAT (Jordan) said that, given its close proximity to the occupied Palestinian territories, his country was acutely aware that Palestinian access to medical facilities was obstructed daily by the closures, restrictions on movement and military checkpoints in place across those territories. The resulting delay in timely access to health care prolonged the suffering of patients, including those needing regular treatment for chronic diseases and pregnant women forced to give birth at checkpoints. The practices of the Israeli authorities also increased mental suffering. Such measures and restrictions violated the most basic human rights norms. Every human being had a right to health and timely access to appropriate health care. He called on all Member States to support the draft decision.

Ms R. RASHEED (Maldives), acknowledging the work of UNRWA in providing humanitarian assistance to Palestinian refugees in the Gaza Strip and occupied territory, said that her Government remained concerned by the restrictions imposed on the movement of patients and health staff and other obstacles to the running and development of the Palestinian health system. It was also deeply concerned that lack of access to the occupied Syrian Golan had prevented the Secretariat from providing a report on health conditions in that area. Humanitarian organizations should have unrestricted access to the area. Maldives had long supported efforts to improve the status of Palestinians, and she supported the draft decision.

Mr LEWIS (Canada) said that, as in previous years, his delegation had concerns about the discussion of such a political matter within WHO, a specialized United Nations body in which there should be no room for politicization. The draft decision under consideration continued to single out

only one side for criticism and called on the Director-General to follow a one-sided approach in the mandate that it would establish. That was inappropriate. For those reasons, he was unable to support the draft decision.

Mr XING Jisheng (China) said that his delegation attached great importance to document A67/41. The rights of those living in the occupied Palestinian territory were a cause for serious concern. The restrictions imposed on the movement of patients and health personnel and the circulation of goods, coupled with the blockade, the checkpoints, and the travel permit regime, had hindered the development of the health system in Palestine and resulted in shortages of medicines and essential medical equipment. WHO had done a great deal of work with a view to setting up a health system in the occupied territory and improving public health. That work should continue. China, also, had provided assistance in order to improve the health situation in the occupied territory. He supported the draft decision.

Mr ALIMUZZAMAN (Bangladesh) was deeply concerned by the continuing deterioration in health and humanitarian conditions in the occupied Palestinian territory and in the occupied Syrian Golan. His Government believed firmly in the principle of the right to health for all, supported the draft decision and urged all Member States to do so without reservation.

Ms STONE (Australia) expressed her country's concern at the poor health conditions of the Palestinian people in the West Bank and the Gaza Strip. The situation highlighted the need for a just and enduring settlement of the conflict. There was no practical alternative to a negotiated, two-State solution, with both sides living in peace and security within internationally recognized borders. She therefore urged Israel and the Palestinians to return to direct negotiations with that end in view. Australia was anxious to support initiatives that would maintain progress towards such a negotiated settlement and therefore continued to provide aid to the Palestinian territories, focusing on strengthening Palestinian institutions and improving basic service delivery for the Palestinian people, including of vital health services. Her delegation had decided to oppose the draft decision because it felt that a stand-alone agenda item on the matter unnecessarily introduced political issues into the World Health Assembly.

Mr GURITNO (Indonesia) said that his Government took every opportunity to work with other entities to advance the Palestinian cause. To that end it was supporting institutional capacity-building, including in the health sector, and had contributed to the construction of a cardiac hospital in the Gaza Strip. He supported the draft decision.

Mr ALEXANDRIS (Greece), speaking on behalf of the European Union, said that, consistent with its view that the Health Assembly should be preserved as a technical body, the European Union, in preparation for the current session, had explored the possibility of a different approach to the agenda item under discussion. Ultimately, it had been suggested that, in order to keep the text as technical as possible, the resolution could be replaced by a decision focusing on the requests made to the Director-General. The European Union appreciated the efforts made by those engaged in the discussion and would vote in favour of the draft decision.

Mr MHANGWANE (South Africa), noting the poor health conditions in the occupied Palestinian territory highlighted in the Secretariat's report, said that his Government was gravely concerned about the Israeli settlement policy and the restrictions on the movement of Palestinians. He called for immediate implementation of resolution WHA65.9 and supported the establishment of medical facilities and the provision of health-related technical support to the Syrian population in the occupied Syrian Golan. He commended the efforts of WHO and other organizations to support the civilian population, especially where health systems were prevented from delivering health services. That support should continue. He fully supported the draft decision.

Dr QADIR (Afghanistan) affirmed that access to health care was not a privilege but a basic need and a right, regardless of the circumstances in which people were living. People living in a conflict situation were more prone than others to both noncommunicable diseases and communicable diseases, such as poliomyelitis. The Palestinian people deserved to have access to health care as a basic right.

Mr ARAFA (Lebanon) requested the addition of Lebanon to the list of sponsors of the draft decision, which affirmed the right to health for all, as enshrined in the WHO Constitution. He could not but echo the grave concerns expressed by other speakers over the health situation endured for decades by Palestinians and Syrians as a result of the occupation.

Mr AL-ABDULLA (Qatar), expressing support for the draft decision, said that his country provided health assistance where needed and called upon all of WHO's 194 Member States to contribute to the provision of such support, not only to Palestinians but to any people requiring health support.

Dr SEITA (Director of Health, UNRWA) said that almost half the people living in the occupied Palestinian territory were refugees and that UNRWA would continue to help them to achieve their full potential in human development, pending a just solution to their plight. As members of the global community, Palestinian refugees had a right to health and access to health care. UNRWA had been striving to respond to the health needs of Palestinian refugees under difficult financial conditions. The Agency had begun to reform its health services in 2011 with the implementation of a people-centred family health team approach. To date, 34 of the 66 health centres in the occupied Palestinian territory had adopted the approach and the remainder were expected to do so by the end of 2015. The use of electronic records was also being expanded.

However, UNRWA's financial situation remained extremely volatile, with an end-of-year deficit of US\$ 69 million forecast for 2014. Health costs, including life-saving medicines for noncommunicable diseases, were rising continuously. Political and social determinants of health were another concern. For example, there was no regular supply of electricity or clean water in the Gaza Strip, where the unemployment level was 40% and 71% of households remained food insecure. Under such conditions, UNRWA's impact on health services was necessarily limited. He urged the global community to enhance its support to UNRWA so that it could continue working to ensure that Palestinian refugees were not left behind in the global effort to achieve universal health coverage.

Dr AYLWARD (Assistant Director-General) acknowledged the comments made by Member States.

The CHAIRMAN recalled the request by the delegate of Israel to proceed to a roll-call vote on the draft decision.

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: Antigua and Barbuda, Belize, Central African Republic, Comoros, Dominica, Grenada, Guinea-Bissau, Marshall Islands, Micronesia, Nauru, Niue, Palau, Saint Lucia, Saint Vincent and the Grenadines, Somalia, Tajikistan, Ukraine and Vanuatu.

Mr NAZIRI ASL (Islamic Republic of Iran) said that before proceeding to the vote, he wished to speak in explanation of vote.

Mr BURCI (Legal Counsel) explained that under Rule 75 of the Rules of Procedure of the World Health Assembly, an explanation of vote was normally given after the vote. However, if the

Committee had no objection, the delegate of the Islamic Republic of Iran might proceed with his explanation before the vote.

Following an objection by Mr MANOR (Israel), the CHAIRMAN said that the Committee would proceed to a roll-call vote. A vote was taken by roll-call, the names of the Member States being called in the French alphabetical order, starting with Afghanistan, the letter A having been determined by lot.

The result of the vote was:

In favour: Algeria, Argentina, Austria, Azerbaijan, Bahrain, Bangladesh, Belarus, Belgium, Benin, Bhutan, Bolivia (Plurinational State of), Botswana, Brazil, Brunei Darussalam, Bulgaria, Chile, China, Costa Rica, Croatia, Cuba, Cyprus, Czech Republic, Democratic People's Republic of Korea, Denmark, Djibouti, Ecuador, Egypt, Estonia, Finland, France, Gabon, Germany, Greece, Guatemala, Guinea, Honduras, Hungary, Iceland, India, Indonesia, Iran (Islamic Republic of), Iraq, Ireland, Italy, Jamaica, Japan, Jordan, Kazakhstan, Kuwait, Latvia, Lebanon, Liberia, Libya, Lithuania, Luxembourg, Malaysia, Maldives, Mali, Malta, Mauritania, Mexico, Monaco, Montenegro, Morocco, Mozambique, Namibia, Netherlands, Nicaragua, Niger, Nigeria, Norway, Oman, Pakistan, Peru, Poland, Portugal, Qatar, Republic of Korea, Republic of Moldova, Romania, Russian Federation, Saudi Arabia, Senegal, Singapore, Slovakia, Slovenia, South Africa, Spain, Sri Lanka, Sudan, Sweden, Switzerland, Syrian Arab Republic, Thailand, The former Yugoslav Republic of Macedonia, Tunisia, Turkey, Uganda, United Arab Emirates, United Kingdom of Great Britain and Northern Ireland, Uruguay, Venezuela (Bolivarian Republic of), Viet Nam, Yemen, Zimbabwe.

Against: Australia, Canada, Israel, Papua New Guinea, United States of America.

Abstaining: Andorra, Armenia, Burundi, Colombia, Congo, New Zealand.

Absent: Afghanistan, Albania, Angola, Bahamas, Barbados, Bosnia and Herzegovina, Burkina Faso, Cabo Verde, Cambodia, Cameroon, Chad, Cook Islands, Côte d'Ivoire, Democratic Republic of the Congo, Dominican Republic, El Salvador, Equatorial Guinea, Eritrea, Ethiopia, Fiji, Gambia, Georgia, Ghana, Guyana, Haiti, Kenya, Kiribati, Kyrgyzstan, Lao People's Democratic Republic, Lesotho, Madagascar, Malawi, Mauritius, Mongolia, Myanmar, Nepal, Panama, Paraguay, Philippines, Rwanda, Saint Kitts and Nevis, 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, United Republic of Tanzania, Uzbekistan, Zambia.

The draft decision was therefore approved by 105 votes to 5, with 6 abstentions.¹

Mr NAZIRI ASL (Islamic Republic of Iran) said that it was regrettable that the Health Assembly had been put in the position of having to consider a draft decision that ignored the deteriorating situation of ordinary people in the occupied Palestinian territory and the occupied Syrian Golan, rather than adopting a robust, comprehensive and action-oriented resolution. That was a clear reversal of WHO's established practice of seeking to improve the health conditions of the innocent Palestinian people in the occupied territory through a solid legal framework. Nevertheless, the Islamic Republic of Iran had voted in favour of the draft decision as an expression of its continuing support for and solidarity with the Palestinian people. Its support of the draft decision should not, however, be

¹ Transmitted to the Health Assembly in the Committee's first report and adopted as decision WHA67(10).

construed as recognition of Israel. It was to be hoped that serious consideration would be given to the adoption of a robust resolution during the Sixty-eighth World Health Assembly.

Ms BOO (Singapore) explained that her delegation's vote in favour of the draft decision was consistent with its long-held view that political considerations should not be introduced into Health Assembly resolutions. It regarded the text of the decision as a step in the right direction.

(For continuation of the discussion, see the summary record of the second meeting, section 1.)

4. PROGRAMME BUDGET AND FINANCIAL MATTERS: Item 20 of the Agenda

Programme budget 2012–2013: performance assessment: Item 20.1 of the Agenda (Documents A67/42 and A67/55)

Dr BAYE LUKONG (Cameroon), speaking in her capacity as Vice-Chairman of the Programme, Budget and Administration Committee of the Executive Board, reported on the Committee's consideration of the Programme budget 2012–2013: performance assessment, as reflected in document A67/55, and noted that the Committee, on behalf of the Executive Board, had recommended that the Health Assembly take note of the summary report contained in document A67/42.

Mr HOLM (Sweden), speaking on behalf of the Nordic countries, Denmark, Finland, Iceland, Norway and Sweden, as well as Estonia and Latvia, observed with satisfaction that the majority of the expected results for the biennium 2012–2013 had been assessed as either fully or partly achieved. The indicators selected for reporting purposes, however, had proved limited when it came to measuring WHO's results. It would be useful to undertake further analysis of the contribution of WHO's work to achievements at the country level and to highlight further the lessons learnt, with a particular emphasis on evaluating the soundness of the original assumptions. Because the report contained in document A67/42 had been written by the WHO offices responsible for the various strategic objectives, it was more descriptive than analytical. For the next report, the Secretariat should strive to strengthen performance assessment and ensure overall coherence by providing a centrally produced analysis for each outcome and/or output. Furthermore, the performance assessment should be combined with the financial report in a single document so as to enable simultaneous evaluation, in keeping with the new programme budget portal, which linked financing with the targets and achieved results. The use of key performance indicators and more graphics would make the report more reader-friendly.

Dr TAKASAKI (Japan) said that the Organization should continue to strive for a realistic budget and appropriate performance levels, in step with the current discussions on WHO reform. Particular emphasis should be placed on the need to reduce costs and to increase flexibility in the voluntary contributions of Member States, which was crucial in order to maximize results. At the same time, accountability to taxpayers at the national level was important. Close attention had to be paid to how the budget was to be used and to what ends, so as to ensure that the activities were understood by and, hence, enjoyed the continued support of the public. In that light, mutually beneficial earmarked funding agreed through constructive dialogue remained worthy of consideration.

Ms CHARTON (Switzerland), expressing appreciation for the quantity of information provided in the summary report (document A67/42), said that genuine results-based reporting required that financing was linked to the objectives and expected results achieved at the three levels of the Organization. Future reports should make it possible to measure results against the indicators. She

supported the suggestion put forward by the delegate of Sweden on combining the performance assessment with the financial report in a single document. She furthermore supported the idea of encouraging donors to accept standardized rather than individual reports as a means of reducing managerial and administrative costs; the Secretariat should explore options for a reporting format that would be widely accepted.

Dr DOGBÉ (Togo), speaking on behalf of the Member States of the African Region, thanked the Secretariat for having taken into account the comments of Member States on the method for assessing Organization-wide expected results. He welcomed the finding that 63% of those results had been assessed as fully achieved in 2012–2013, which was an improvement with respect to the previous biennium. However, particular attention should be paid to strategic objectives 1, 2, 3, 5, 11 and 13, where most of the expected results had been rated “partly achieved”. Efforts should also be stepped up with regard to objectives 7 and 9, which remained major areas of concern for African countries. Measures should also be taken to improve the achievement rate for objective 5, where none of the expected results had been fully achieved. Noting the problems associated with high levels of earmarking of funding, alluded to in paragraph 141 of the summary report, he encouraged donors to cooperate with partners in ensuring that the level of financing for the forthcoming budget was more evenly distributed across all budget segments and to provide more flexible funding.

Ms R. RASHEED (Maldives) said that although the overall level of funding for the Programme budget 2012–2013 had been relatively high, the misalignment of available funding across budget segments and strategic objectives, as well as between regions, was an issue requiring special attention. Bearing in mind the high disease burden in the countries of South-East Asia and the fact that they accounted for a quarter of the global population, the number of staff members assigned to deal with public health issues in the Region was inadequate and any further budget cuts would undermine effective programme management. A shift from the current over-reliance on earmarked funds to more flexible forms of funding would help to redress the disproportions in the allocation of the Organization’s funds and expedite the implementation of programmes, the elimination of health inequities and the attainment of WHO’s overall objectives.

Dr TROEDSSON (Assistant Director-General) said that the Secretariat’s efforts to improve reporting appeared, in the light of the various speakers’ comments and the discussions at the twentieth meeting of the Programme, Budget and Administration Committee, to be moving in the right direction. The Secretariat recognized, however, that the summary report contained in document A67/42 was too descriptive and that more analytical work was required. It would follow up on the suggestion that performance assessments and financial reports should be combined into a single document. As for key performance indicators, the Secretariat was exploring ways of improving performance assessment at all three levels of the Organization for the Programme budget 2016–2017, including through an assessment of which indicators were genuinely measurable and how achievements could be validated. He welcomed the suggestion of developing a standardized reporting format, which would indeed help to reduce the Secretariat’s workload and its management and administrative costs. The Secretariat would look at options and present a proposed format to Member States and donors.

The Committee noted the report.

Financial report and audited financial statements for the year ended 31 December 2013:
Item 20.2 of the Agenda (Documents A67/43, A67/43 Add.1 and A67/56)

Dr BAYE LUKONG (Cameroon), speaking in her capacity as Vice-Chairman of the Programme, Budget and Administration Committee of the Executive Board, reported on the Committee’s discussion of the Director-General’s financial report and the audited financial statements

for the year ended 31 December 2013, as reflected in document A67/56. It had recommended, on behalf of the Executive Board, that the Health Assembly adopt the draft resolution contained in paragraph 9 of that document, accepting the report and financial statements, and the draft resolution contained in paragraph 6 of document A67/43 Add.1, which proposed that the balance of the Member States' Assessed Contributions Fund be used to help cover long-term staff liabilities and build up a reserve in the Real Estate Fund for capital financing.

Ms CARTER (Australia) said that continued work on WHO reform would help to address structural financial risks, increasing the scope for resource mobilization and more flexible funding allocation. Given the uneven distribution of financing across various budget segments, which affected the achievement of expected results, it was important to ensure the success of the Organization's resource mobilization strategy. She supported the use of the balance of the Member States' Assessed Contributions Fund for the purposes proposed in the draft resolution contained in document A67/43 Add.1.

The CHAIRMAN said that, in the absence of any objection, he would take it that the Committee wished to approve the draft resolution contained in document A67/56.

The draft resolution was approved.¹

He then invited the Committee to consider the draft resolution contained in document A67/43 Add.1.

The draft resolution was approved.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:
Item 20.3 of the Agenda (Documents A67/44 and A67/57)

Mr JEFFREYS (Comptroller) informed the Committee that payments of assessed contributions had been received from the following four Member States since the previous week's twentieth meeting of the Programme, Budget and Administration Committee of the Executive Board: Bosnia and Herzegovina, Côte d'Ivoire, Malawi and Senegal. As they were no longer subject to the provisions of Article 7 of the Constitution, those countries should be deleted from the lists in the third and fourth preambular paragraphs of the draft resolution contained in paragraph 5 of document A67/57, and Senegal should also be deleted from the list in operative paragraphs 1 and 2.

Mr QASEM (Jordan) said that his Government was in the process of approving payment of its assessed contribution and requested that the reference to Jordan also be deleted from the third preambular paragraph of the draft resolution.

The CHAIRMAN said that the request by the delegate of Jordan had been noted and that, seeing no objection, he took it that the Committee wished to approve the draft resolution, as amended.

The draft resolution, as amended, was approved.³

The meeting rose at 17:20.

¹ Transmitted to the Health Assembly in the Committee's first report and adopted as resolution WHA67.3.

² Transmitted to the Health Assembly in the Committee's first report and adopted as resolution WHA67.4.

³ Transmitted to the Health Assembly in the Committee's first report and adopted as resolution WHA67.5.

SECOND MEETING

Thursday, 22 May 2014, at 09:15

Chairman: Dr R. RUGUNDA (Uganda)

later: Dr S. AKAUOLA (Tonga)

- 1. HEALTH CONDITIONS IN THE OCCUPIED PALESTINIAN TERRITORY, INCLUDING EAST JERUSALEM, AND IN THE OCCUPIED SYRIAN GOLAN:** Item 19 of the Agenda (Documents A67/41, A67/INF./2, A67/INF./3, A67/INF./4 and A67/INF./5) (continued from the first meeting, section 3)

Dr QADIR (Afghanistan) said that his delegation had been unable to be present for the vote on the draft decision relating to item 19 of the agenda. Had his delegation been present, it would have voted in favour of the text.

The CHAIRMAN said that, although the results of the vote would remain as they had been announced, the statement of the delegate of Afghanistan had been noted.

- 2. FIRST REPORT OF COMMITTEE B:** (Document A67/66)

Dr SINGH (Nepal), Rapporteur, read out the draft first report of Committee B.

The report was adopted.¹

- 3. AUDIT AND OVERSIGHT MATTERS:** Item 21 of the Agenda

Report of the External Auditor: Item 21.1 of the Agenda (Documents A67/45 and A67/58)

Dr BAYE LUKONG (Cameroon), speaking in her capacity as Vice-Chairman of the Programme, Budget and Administration Committee of the Executive Board, introduced the Committee's report on the item (document A67/58). The Committee, on behalf of the Executive Board, had recommended the adoption of the draft resolution contained in its report.

Mrs TAN (External Auditor) introduced the report of the External Auditor (document A67/45). In 2013, financial, compliance, value-for-money and performance audits had been conducted at various locations, including WHO headquarters, the Global Service Centre, and regional and country offices. Based on the International Public Sector Accounting Standards (IPSAS), the External Auditor had issued an unqualified audit opinion on the financial statements for the financial period ending on 31 December 2013. The key issues addressed in the report included reporting to donors, direct financial cooperation, the accountability framework, including the whistleblower policy and the asset

¹ See page 349.

accountability policy for lost assets, procurement, staff performance review and the internal control systems in regional and country offices.

Mr KUEMMEL (Germany) strongly supported the External Auditor's recommendations and noted that, in 2013, expenditure on procurement had amounted to one third of overall spending, making it the second largest expense category for the Organization. The lack of formal strategic procurement planning and the weak controls for procurement were causes for concern, particularly given the level of expenditure involved. A strategic approach to procurement planning would ensure that the best quality was obtained at optimal cost. About 9000 non-staff working for WHO were included in the category of procurement of services; it would be more appropriate for the strategic oversight of those persons to be provided by the department of human resources.

In view of weaknesses in field offices, he supported the External Auditor's recommendation to implement a long-standing solution for internal controls at the three levels of the Organization and the recommendation that WHO should strengthen the capabilities of regional and country offices in conducting risk assessment and assurance activities relating to direct financial cooperation. An update on progress made by the newly established Office of Compliance, Risk Management and Ethics would be welcome.

Ms NISHIMURA (Japan) noted the need for external auditing, owing to the difficult financial situation. She requested that a commitment be made to take appropriate action on personnel and procurement issues and that the recommendations of the current and previous audit reports be followed up.

Ms BLACKWOOD (United States of America) noted that the reports of the External and Internal Auditors and the Independent Expert Oversight Advisory Committee highlighted the need for stronger internal controls. Her delegation had already emphasized the need for immediate action on the recommendations on procurement, specifically the need for a strategic procurement planning process and appropriate policies at all levels and all locations of WHO to ensure that vendors complied with the highest ethical standards.

She commended the WHO requirement that the "specific, measurable, achievable, relevant and time-bound" model be used for setting staff's objectives, since they were a critical component of any performance management system. She asked for information on training for staff and managers and whether the department of human resources reviewed the quality of the objectives, particularly in relation to the Organization's goals.

Ms KAINE (Australia) noted the substantial work performed by the External Auditor and welcomed the recommendations to improve the efficiency of the administration and management of WHO's operations. Timely implementation of the recommendations in the 2013 report would ensure the effective use of resources and good management of taxpayer funds. She urged WHO to draw up a plan, as suggested by the External Auditor, to implement all the audit report recommendations from the financial years 2010 to 2012, over one third of which were outstanding.

Mr DIKMEN (Turkey) welcomed the introduction of measures to improve the areas of human resources, procurement, direct financial cooperation, and performance management. He supported the External Auditor's recommendations on direct financial cooperation and firmly believed that the provision of adequate and timely information to all counterparts was crucial to improvements in management and measuring progress. He supported the recommendations for improved reporting.

As a member-led organization, the progress of WHO should be closely monitored by its Member States: to that end, he asked the Secretariat to improve monitoring and evaluation mechanisms.

Mr BARROS (Cabo Verde), speaking on behalf of the Member States of the African Region, noted that the External Auditor had found the Organization's accounts for 2013 to be in order and in compliance with the International Public Sector Accounting Standards. Recommendations had been made to support the Organization's goals to empower staff; increase transparency; improve financial management and governance; and strengthen internal control systems in country offices.

The External Auditor's recommendations from previous years had all been implemented or were in the process of implementation, save one. He encouraged the Secretariat to implement the recommendations in order to overcome the challenges facing the African Region, and called on all Member States to approve the financial reports and to step up effective implementation of the recommendations.

Dr GHEBREHIWET (Eritrea), supplementing the information provided by the previous speaker, said that the Member States of the African Region wished to highlight the major risk areas that had been identified as a result of the audits conducted in 2013, which included reporting on direct financial cooperation by counterparts, adherence to procurement rules (competitive bidding and obtaining best value for money), imprest and cash management (heavy reliance on cash payments, which increased exposure to fraud), and fixed asset management.

Member States of the African Region faced a very difficult external environment in terms of political and economic security and infrastructure conditions, recruitment and retention of qualified staff, and challenges related to the volume of transactions, poor connectivity and a lack of funding for management and administration.

Dr TROEDSSON (Assistant Director-General), thanking delegates for their comments, said that a useful discussion on the audits had also been held by the Programme, Budget and Administration Committee of the Executive Board. He assured the Committee that implementation of the External Auditor's recommendations and the introduction of adequate controls had received significant attention at the three levels of the Organization and from senior management. The External Auditor had observed an improvement in compliance in 2013 compared with 2012. With regard to the comment by the delegate of Australia, it was his understanding that outstanding recommendations that had yet to be implemented mostly related to the report of the Internal Auditor.

It was clear that procurement was an area of risk for the Organization, as mentioned by a number of delegates. Procurement was the second largest area of expenditure and it covered a mix of goods and services. As advised by the delegates of Germany and the United States of America, the Secretariat would adopt strategic procurement planning and develop standard operating procedures that would help to distinguish between goods and services, while a procurement checklist was being developed for use at headquarters and at the regional and country levels. Controls on procurement would be improved through an integrated approach that would increase the involvement of the human resources department. Instead of the compartmentalized approach of the past, technical units would work together with the Global Service Centre during the procurement process.

Regarding compliance and internal controls, the Office of Compliance, Risk Management and Ethics had been established at headquarters, alongside compliance and control units in the regional offices. A network had been established to standardize approaches to internal control and risk assessment.

A new approach to performance assessment would set out clear objectives and indicators for achievements over the year, in accordance with the accountability compact between the Director-General and senior management. The standardized objectives and indicators would also be used for the staff under assistant directors-general.

Dr SMITH (Executive Director, Office of the Director-General) said that the Office of Compliance, Risk Management and Ethics had been established in 2013 as part of WHO reform and, as of 2014, it was fully staffed. Its main area of work in risk management had been to develop and pilot a corporate risk register template, which would be introduced throughout the Organization in

2014. The risk mitigation phase of implementation should be completed by the end of the year, and progress would be reported to the Executive Board in January 2015.

Regarding compliance and ethics, the relationship between the Office at headquarters and the compliance units in each region was being strengthened and common tools were being developed for programme and administration review.

The whistleblower policy, an area of work highlighted by the Programme, Budget and Administration Committee, had been updated and reviewed in line with existing policies within organizations in the United Nations system. The policy on conflict of interest had also been updated and would be implemented in 2014. It would involve establishing a database of experts in order to improve transparency and information sharing across the Organization, including on declarations of interest.

The CHAIRMAN said that, if he heard no objections, he would take it that the Committee wished to approve the draft resolution contained in document A67/58.

The draft resolution was approved.¹

Report of the Internal Auditor: Item 21.2 of the Agenda (Documents A67/46 and A67/59)

Dr BAYE LUKONG (Cameroon), speaking in her capacity as Vice-Chairman of the Programme, Budget and Administration Committee of the Executive Board, introduced the Committee's report on the item (document A67/59). The Committee, on behalf of the Executive Board, had recommended that the Health Assembly note the report of the Internal Auditor (document A67/46).

Mrs SHIPTON-YATES (United Kingdom of Great Britain and Northern Ireland) welcomed the progress made in strengthening the effectiveness of control and oversight and the creation and full staffing of the Office of Compliance, Risk Management and Ethics, as well as the implementation of the plan to strengthen the Office of Internal Oversight Services. Resources must not be diverted from audit and oversight to other functions, such as handling harassment or complaints cases. The corporate risk register should be finalized and implemented by 2015. The whistleblower policy should be revised, and a more robust reporting system for suspected incidents of fraud and wrong-doing would be welcomed. The internal control framework should be strengthened and a comprehensive, factual and tangible assessment of implementation of the overall control framework at the three levels of the Organization should be undertaken and reported on regularly. She encouraged the Secretariat to pursue the development of a strategic procurement planning process and to ensure that all audit recommendations were followed up in a timely and effective manner.

Mr KUEMMEL (Germany) said that his Government strongly supported the commitment of senior staff to improving the accountability framework. Cultural shifts took time, but he was confident that the Organization was on track to strengthen internal controls. He was concerned by the Internal Auditor's findings that control processes in the global procurement and logistics unit of the Global Service Centre provided inadequate assurances that value for money had been obtained and that effective procurement procedures had taken place. The processing team focused on verifying the completeness of supporting documentation rather than reviewing the suitability of its contents. The global procurement and logistics unit was not fully resourced and was therefore unable to ensure compliance and consistency with WHO's rules and regulations. The Secretariat was urged to take immediate steps to strengthen the unit and to report on the action taken in 2015.

¹ Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA67.16.

Given the scale of direct financial cooperation – more than US\$ 500 million per biennium – and the concern of the Internal Auditor with regard to 16 of the 18 cases of direct financial cooperation audited, it was clear that such cooperation posed a severe financial and reputational risk to the Organization. Responsibility for direct financial cooperation was shared between Member States and the Secretariat, and he was confident that initial steps had been taken to review the problems. He urged the Secretariat to lose no time in implementing effective policies to avoid the recurrent deficiencies described in the report of the Internal Auditor.

Mr LUTNÆS (Norway), speaking on behalf of Denmark, Estonia, Finland, Iceland, Norway and Sweden, said that it was important to ensure that unused direct financial cooperation funds were returned and that the use of funds was adequately reported. It seemed clear from the remarks of the Internal and External Auditors that direct financial cooperation was an area deserving of serious attention from a risk management perspective and improved accountability through regular, adequate, timely and systematic control routines based on clear expectations, roles and requirements. The desk review of current practices and guidelines on direct financial cooperation, particularly with regard to country offices, was welcomed, and the Secretariat was encouraged to draw lessons from the harmonized approach to cash transfers that was applied by a number of organizations in the United Nations system to tackle similar issues of risk management. He looked forward to holding a full and informed discussion on the matter in governing bodies meetings. He encouraged WHO to enable easy access on the WHO website to relevant audit documents such as the Office of Internal Oversight Services work plan and previous audits and their follow-up.

Dr TROEDSSON (Assistant Director-General), responding to the remarks by the delegate of the United Kingdom of Great Britain and Northern Ireland, said that the Organization was a victim of its own success because the Office of Internal Oversight Services was able to use the Global Management System to carry out desk reviews and therefore detected more issues that needed to be addressed. It was hoped that the number of issues would fall, however, once such transparent methods had been fully implemented. The problems concerning the internal controls for procurement processes at the Global Service Centre were not acceptable, and he assured the delegate of Germany that they were being addressed.

The huge functional and accountability problems with direct financial cooperation were recognized, and responsibility for them was shared between the Secretariat and Member States. Although direct financial cooperation was a useful tool, financial and technical reporting by national counterparts was often inadequate; many ignored reporting obligations once they had received the money and sanctions such as blacklisting were ineffective. A global review of direct financial cooperation would be launched, and the Director-General had threatened to abandon direct financial cooperation altogether if no improvement was seen.

In response to remarks by the delegate of the United Kingdom of Great Britain and Northern Ireland, he noted that progress was being made in the implementation of internal controls. A guide and checklist for managers was being finalized, and training materials were being developed for staff on accountability, risk management and internal controls. The harmonized risk management framework would be introduced throughout the Organization in 2014 and 2015, and progress would be reported to the governing bodies in 2015. New staff were given induction training that included an important component on the internal control framework and risk management.

Mr WEBB (Office of Internal Oversight Services) thanked delegates for their support for the work of the Office of Internal Oversight Services. The Office encouraged an end-to-end view of the procurement process, in order to find the points of greatest risk in the cycle and to address the issues reported at country level and in the Global Service Centre.

A global audit of direct financial cooperation was under way and, once the report had been considered and management responses had been collected, Member States would be consulted before the 136th session of the Executive Board, in January 2015.

He assured the delegate of Norway that the Office was considering procedures such as the harmonized approach to cash transfers to address the issues affecting direct financial cooperation, including the shared responsibility of the Secretariat and Member States for such cooperation. Furthermore, work was being done to find a solution that would facilitate remote access for Member States to audit reports, in addition to the physical access provided by visits to the Office in Geneva.

The Committee noted the report.

4. STAFFING MATTERS: Item 22 of the Agenda

Human resources: annual report: Item 22.1 of the Agenda (Documents A67/47 and A67/60)

Dr BAYE LUKONG (Cameroon), speaking in her capacity as Vice-Chairman of the Programme, Budget and Administration Committee of the Executive Board, introduced the Committee's report on the item (document A67/60). The Committee, on behalf of the Executive Board, had recommended that the Health Assembly note the human resources annual report (document A67/47).

Mr HOLM (Sweden), speaking on behalf of Denmark, Estonia, Finland, Iceland, Latvia, Norway and Sweden, welcomed the measures taken on performance management and increased mobility. At the country level, however, the related component was not in place. The work of human resources at country level should be based on a transparent assessment of human resources needs that accompanied bottom-up planning for the next biennium. Once needs had been assessed, they could be used as the basis for recruitment. Such a system should be implemented during the 2014–2015 biennium.

Providing an enabling working environment was a key factor in promoting gender equality and empowering women and men with children. A family-friendly approach should go beyond flexitime and teleworking to include measures such as paid leave for parents when a child was ill. Such measures would keep WHO at the forefront of developments as a modern United Nations entity.

It was essential to address the legacy of the Global Polio Eradication Initiative, and he welcomed the measures taken so far by the Secretariat. It was especially important that the sustainability of core public health functions, such as surveillance and national immunization programmes, was ensured through national funding channels. National immunization activities should not be maintained by staff funded by the Initiative.

Dr KISAKA (Japan) welcomed the attention paid by the Programme, Budget and Administration Committee to the issues of geographical, gender and generational balance within WHO. Many Member States, however, particularly those in the Western Pacific Region, were under-represented or not represented at all. Tackling the problem of under-representation would strengthen the diversity and integrity of WHO.

Ms GARCÍA ARREOLA (Mexico) acknowledged the staffing profile and information on staff costs contained in the report. She welcomed the information provided on human resources financed from polio-specific funds, as requested by the Programme, Budget and Administration Committee at its meeting in January 2014. She suggested that the report present the current composition of the Global Polio Eradication Initiative's human resources infrastructure, and a table showing the roles and activities carried out by those personnel holding staff contracts and those holding non-staff contracts that were financed from polio-specific funds in polio-free countries, as it was mentioned that those staff were used for additional health priorities. She also expressed concern at financial liabilities related to indemnity costs for staff funded by the Initiative and asked the Secretariat to keep the

Executive Board informed of the measures taken to contain those liabilities or at least ensure that they did not increase.

Mr KUEMMEL (Germany) said that although the report had provided useful information on the current status of human resources at WHO, it would be helpful to gain a better understanding of the Secretariat's thinking on future staff composition. He therefore urged the Secretariat to provide a short report at the next sessions of the governing bodies on how it envisaged implementing the revised human resources strategy.¹

The end of polio-related funding in 2019 would have consequences at every level of the Organization. The report contained in document A67/38 showed that staffing levels in polio-free countries had remained stable and that long-term human resources planning was essential for staff funded by the Global Polio Eradication Initiative. He supported the conclusions of the report and expected that human resources management practices would be standardized and improved. In addition, he requested regular updates on developments in the Polio, Emergencies and Country Collaboration cluster.

Overall, 13% of WHO staff appeared to be working on or funded through poliomyelitis eradication, with that figure reaching 37% in areas with a current focus on poliomyelitis eradication. In the African Region, the end of polio-related funding could lead to the loss of over a third of the staff, significantly changing the shape of the Organization. Transition planning was therefore not an isolated issue for the Polio, Emergencies and Country Collaboration cluster but rather a need for the entire Organization.

Considering the lessons that could be learnt from the decentralized handling of human resources in the Polio, Emergencies and Country Collaboration cluster, it was clear that contractual arrangements varied significantly across regions: the potential financial liabilities for the Organization could not be accepted by the governing bodies. The human resources strategy would have to include effective ways of aligning practices across WHO. It was also important that the department of Human Resources Management at headquarters should be able to set standards for WHO in all regions, including on adequate staffing levels and clear reporting lines to headquarters.

Dr YANSANE (Guinea), speaking on behalf of the Member States of the African Region, congratulated the Secretariat on its efforts to attain balance in the Organization's human resources. He noted that staff costs had generally been kept under control during 2013. The Secretariat should continue its efforts to increase the representation of women and of under-represented countries and regions. He recognized the Secretariat's efforts to rejuvenate the Organization's workforce, with an increase in the number of staff under 50 years old. He asked the Secretariat to be mindful of the impact of possible poliomyelitis eradication on other parts of the Organization.

Mrs SHIPTON-YATES (United Kingdom of Great Britain and Northern Ireland) said that the Organization's staff were the key resource it needed in order to fulfil its strategic objectives. As mentioned in the report of the Independent Expert Oversight Advisory Committee,² the implementation of the new human resources strategy and its related policies would be critical to the success of WHO reform, and it was therefore crucial that those policies were appropriate. She appreciated the oral update given during the twentieth meeting of the Programme, Budget and Administration Committee of the Executive Board but reiterated her request for regular written updates on the implementation of the strategy. Future human resources reports should be more strategic and could include a section reporting on progress made to implement new human resources policies, information on what the Secretariat was doing to manage and improve the staff performance

¹ Document EB134/INF./2.

² Document EBPBAC20/3.

management system, and clear reference to targets and benchmarks for gender, staff mobility and geographical representation.

Mr KIM Young-hak (Republic of Korea) commended the movement towards gender parity and the increase in the representation of women. However, more needed to be done to improve geographical representation. To that end, the Secretariat should analyse the current situation and reason for the under-representation of some countries. Member States should also make efforts at the country level. When preparing a new recruitment plan, it was important to consider not only recruitment for the next 10 years but also the possibility of increasing the retirement age, the cost and effectiveness of human resources, and various other factors.

Mr DIKMEN (Turkey) said that the report provided specific and valuable data on the distribution and diversity of WHO staff. Its descriptive nature needed to be supported with analytical comparisons and conclusions. He noted the figures for geographical representation and asked whether any study had been conducted or planned in the near future to discover the reasons for under- and over-representation and envisage appropriate measures to correct them. He requested the Secretariat to provide information on the matter in future reports, as well as an analysis of the impact of the revised human resources strategy on the work and performance of the Organization.

Mr VEGA MOLINA (Spain) said that human resources were one of the pillars of WHO reform. He thanked the Secretariat for regularly posting its list of job vacancies, which added to its efforts to improve transparency. He supported the revised human resources strategy's three pillars but considered that its timeline for implementation could be shortened. It was important that Secretariat reports should include more detailed information on salaries and allowances, which would aid Member States' understanding. He welcomed the application of the International Public Sector Accounting Standards for the second year running, which would enable adequate future evaluation of the Organization's financial liabilities, including those related to staff assigned to the Global Polio Eradication Initiative.

Dr ELABASSI (Sudan) commented that the report to some extent indicated a response to staff needs, but what efforts were being made to respond to health system needs in terms of staff capacities and skills? A response to country needs was an urgent imperative, as health systems were shifting towards integration and WHO must have a clear perspective on that shift, especially in the light of the discussion of health in the post-2015 era. In matters of staff selection, there were no objective or scientific criteria for ascertaining whether geographical representation and gender balance were taken into account. Nor was there any specific training for disasters and emergencies, yet disaster preparedness was vital and a strategic human resources issue to which WHO must give consideration.

Dr TROEDSSON (Assistant Director-General) said that WHO was a knowledge-based organization, and its staff were its core asset. Reform of human resources was key to the success of most areas of WHO reform. The first pillar of the revised human resources strategy, attracting talent, concerned the recruitment of a highly skilled and qualified workforce with an improved gender balance and fair geographical representation. A more timely selection process was required across the Organization. The second pillar, retaining talent, relied on career management and workforce planning, as well as performance management and staff mobility. The Secretariat had initiatives in those areas and was aligning staffing with the Organization's new priorities. In response to requests by the delegates of Germany, the United Kingdom of Great Britain and Northern Ireland, and Turkey, the Secretariat would regularly report to Member States on the progress of implementation of the revised human resources strategy, through written updates and weekly outreach communications to Member States' permanent missions in Geneva. In response to the comments of the delegate of Sweden, the process of achieving better staff competence profiling at country level would take time, but the Secretariat was trying to implement that process in three ways: in the long term, through country

cooperation strategies to identify the required staffing; in the short term, through bottom-up planning to see what staff would be required at country level for the programme budget for 2016–2017; and through more dynamic staff mobility to fill positions and change the staffing profile. A new policy on mobility would be presented to senior management and, it was hoped, would be implemented in 2015.

Ms LINKINS (Polio, Emergencies and Country Collaboration) said that regular updates on the composition of the workforce funded by the Global Polio Eradication Initiative would be provided in future human resources reports. In response to the concerns expressed by delegates, the Secretariat would issue guidelines to standardize the human resources practices and processes for the polio programme and to monitor progress. It would establish a fund to cover any terminal indemnities and separation costs arising from completion of the Global Polio Eradication Initiative. A study would be initiated, through the polio legacy planning process, to document the nature of the activities carried out by the human resources infrastructure funded by the Initiative, as well as potential transition options, in collaboration with development actors, other health initiatives and governments. The Secretariat was undertaking the long-term human resources planning process as recommended by Member States, in order to plan for staff funded by the Initiative to the end of 2018 upon the eventual completion of the Global Polio Eradication Initiative. It expected to complete the planning process by mid-2015 and would report on its conclusions. By mid-2015, the Secretariat would initiate work with national governments in the 10 countries that comprised 90% of the current human resources infrastructure funded by the Initiative to discuss and plan for transition measures.

The Committee noted the report.

Report of the International Civil Service Commission: Item 22.2 of the Agenda (Document A67/48)

The Committee noted the report.

Amendments to the Staff Regulations and Staff Rules: Item 22.3 of the Agenda (Documents A67/49 and EB134/2014/REC/1, resolution EB134.R12)

The CHAIRMAN invited the Committee to consider the draft resolution recommended by the Executive Board in resolution EB134.R12. If he heard no objections, he would take it that the Committee wished to approve the draft resolution.

The draft resolution was approved.¹

Appointment of representatives to the WHO Staff Pension Committee: Item 22.4 of the Agenda (Document A67/50)

The CHAIRMAN proposed the nomination of Dr Ebenezer Appiah-Denkyira (Ghana) as a member of the WHO Staff Pension Committee for a three-year term until May 2017, and Dr Michel Tailhades (Switzerland) as a member of the WHO Staff Pension Committee for the remainder of his term of office until May 2015. He further proposed the nomination of Dr Darren Hunt (New Zealand) and Dr Mariam A. Al-Jalahma (Bahrain) as alternate members of the WHO Staff Pension Committee for three-year terms until May 2017.

It was so decided.²

¹ Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA67.17.

² Transmitted to the Health Assembly in the Committee's second report and adopted as decision WHA67(11).

The CHAIRMAN invited the Committee to join him in paying tribute to the late Dr Ali Jaffer Mohamed, former member of the delegation of Oman, who had died in May 2013. Dr Mohamed had contributed extensively to the work of the WHO Staff Pension Committee.

The Committee paid tribute to Dr Mohamed.

5. MANAGEMENT AND LEGAL MATTERS: Item 23 of the Agenda

Follow-up of the report of the Working Group on the Election of the Director-General of the World Health Organization: Item 23.1 of the Agenda (Document A67/51)

Dr MAKUBALO (South Africa), speaking on behalf of the Member States of the African Region, thanked the Secretariat for having consolidated a description of the process for the election of the Director-General in a clear, succinct report. She supported the proposals made regarding administrative processes under the Code of Conduct for the Election of the Director-General, which would protect the integrity, high standards and good example set by WHO. She expressed support for the principles of the Code of Conduct, which needed to be safeguarded and protected. She noted the principle of ensuring effective harmonization and alignment of procedures between regions and headquarters, which had been outlined as part of WHO reform. The process of electing a new Regional Director for Africa would be concluded that year. She was confident that the report would provide the African Region with the necessary guidance for the purpose of harmonizing the rules of procedure in relation to the nomination process. WHO was demonstrating that it was always learning and was a responsive organization. The reforms would enrich and further strengthen the process of electing future directors-general.

The Committee noted the report.

Real estate: update on the Geneva buildings renovation strategy: Item 23.2 of the Agenda (Documents A67/52 and A67/61)

Dr BAYE LUKONG (Cameroon), speaking in her capacity as Vice-Chairman of the Programme, Budget and Administration Committee of the Executive Board, introduced the Committee's report on the item (document A67/61). The Committee, on behalf of the Executive Board, had recommended that the Health Assembly adopt the amended draft decision contained in that document.

Ms CHARTON (Switzerland) said that, as the Host State, Switzerland had a particular interest in the Organization having renovated and adequate building stock that offered international civil servants the best working conditions. The updated Geneva buildings renovation strategy was an economical and efficient long-term solution to meet the Organization's real estate needs. It would enable WHO to have buildings that complied with the latest environmental performance and fire safety standards. She supported the renovation strategy. It was time to move forward to the planning phase. She hoped that the draft decision would receive the support of many Member States. It was Member States' responsibility to provide sufficient funding for the renovation: a total contribution of 25 million Swiss francs per biennium would be enough to guarantee the majority of work on existing buildings and avoid difficulties in the future.

Ms GIROD (United Kingdom of Great Britain and Northern Ireland) welcomed the update on the Geneva buildings renovation strategy. She could support the strategy on the basis that, at the

current stage, the Secretariat was only asking for agreement to explore the strategy further, including by launching the architectural competition. Underinvestment in real estate and maintenance could not continue, and postponing the issue was not cost-efficient. She requested a full and detailed proposal, including on financing, to be shared with Member States in advance of the Sixty-eighth World Health Assembly. She sought clarification from the Secretariat on how it would incorporate into the strategy the lessons learnt from other major capital master plans, including that of the United Nations headquarters in New York. It would be helpful to know how the future needs of WHO would be reflected in the proposal. How would the project be managed in order to ensure it was delivered on time and within the agreed budget?

Mr PRESTON (Operational Support and Services) thanked Switzerland for its invaluable collaboration on the renovation project. The Secretariat would provide the information requested by the delegate of the United Kingdom of Great Britain and Northern Ireland prior to the decision to construct the new building, which would be made at the Sixty-ninth World Health Assembly. The Organization's most recent construction project, the WHO/UNAIDS building at headquarters, had been built within budget and had been cited by the Joint Inspection Unit as a model for implementation. The oversight committee would be expanded to include representatives of Member States.

The CHAIRMAN took it that the Committee wished to approve the amended draft decision contained in document A67/61.

The draft decision was approved.¹

6. COLLABORATION WITHIN THE UNITED NATIONS SYSTEM AND WITH OTHER INTERGOVERNMENTAL ORGANIZATIONS: Item 24 of the Agenda (Document A67/53)

Ms BLACKWOOD (United States of America) said that collaboration had always been an important exercise, and was especially important at a time when available resources might not be keeping pace with the new and expanded responsibilities that Member States and donors expected of intergovernmental organizations. She welcomed WHO's commitment to efforts such as the "Delivering as One" approach and initiatives to develop shared and common services, such as through its global and regional service centres. She urged continued participation in joint efforts, such as initiatives undertaken by the United Nations System Chief Executives' Board for Coordination's High-Level Committee on Management in areas such as harmonization of business practices. Such efforts promoted best practices among organizations of the United Nations system and created opportunities to identify efficiencies and promote streamlining, which enabled WHO and other organizations of the United Nations system to maximize the use of available resources.

Dr SHOHANI (Iraq) said that system-wide collaboration promoted optimal investment of resources and helped to prevent duplication of programmes and activities. In Iraq, the collaboration coordinated to that end within the framework of the United Nations Institute for Training and Research had strengthened the United Nations partnership with the Ministry of Health and other Government entities, as well as opening up opportunities for partnership with other supporting bodies and organizations. A technical group had accordingly been formed as part of a United States Agency for International Development-supported primary health care project. The group's regular meetings

¹ Transmitted to the Health Assembly in the Committee's second report and adopted as decision WHA67(12).

were attended by representatives of organizations of the United Nations. The Government had adopted the same collaborative approach to expenditure, securing support for joint financial planning to enhance primary health care activities, thereby attaining Millennium Development Goal 8 (Develop a global partnership for development).

Dr ELABASSI (Sudan) said that discussions of multifaceted support to countries were always perplexing. The Paris Declaration on Aid Effectiveness, administered by WHO and partners within the framework of the International Health Partnership, was the best framework for accommodating health interventions in the interests of sustainability, efficiency, alignment and harmonization. Such action should be based on a strategic national plan in which all counterparts were part and parcel of the process, creating a collaborative mechanism operating on the basis of the priorities of the country concerned and in the interests of its population.

The Committee noted the report.

Dr Akauola took the Chair.

7. HEALTH SYSTEMS: Item 15 of the Agenda [Transferred from Committee A]¹

Traditional medicine: Item 15.1 of the Agenda (Documents A67/26 and EB134/2014/REC/1, resolution EB134.R6)

Dr SHOHANI (Iraq) said that it was important to strengthen health systems through modernization and quality assurance with a view to effecting constant improvements and delivering effective preventive and therapeutic health services. Traditional medicine must be integrated into essential medicine in a non-contradictory manner and practised within an institutional framework, with an emphasis on scientific concepts, rather than in a haphazard fashion. Traditional medicine institutions must be twinned with academic health institutions in the interest of ensuring that they were properly certified, and traditional medicine should also feature among the subjects taught at schools of medicine and as part of training programmes complementing those run by ministries of health.

Mr AL ATAWI (Bahrain), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that traditional or complementary medicine was practised on a wide scale in the Middle East but outside the national health systems. There was also little systematic quality or safety control of herbal medicines, which were generally unregulated, and such regulations as did exist were poorly enforced, meaning that traditional therapists were not registered. Few Middle Eastern countries carried out formal monitoring of traditional medicine, media advertising of traditional medicines and products to consumers was unregulated, and national strategies for research into traditional medicine were non-existent. The WHO traditional medicine strategy: 2014–2023 must therefore be implemented in the countries of the Region, which must also develop national policies on traditional medicine or establish traditional medicine watchdogs as part of their drug monitoring regimes. WHO should furthermore provide technical support to the relevant national bodies in charge of efforts to regulate traditional medicine practitioners and products. He expressed support for the draft resolution recommended by the Executive Board in resolution EB134.R6.

Ms DURAN (Plurinational State of Bolivia) said that in the Plurinational State of Bolivia traditional medicine contributed towards improving the health of the population and was a component

¹ See the summary records of the General Committee, second meeting, section 2.

of family and community health within a context of general well-being. It was clearly stated in the Constitution that the Government had a responsibility to promote and ensure that traditional medicine, its use and related research was respected, and that traditional knowledge and practices from all countries and indigenous peoples should be preserved. A total of 36 indigenous peoples were recognized under the Constitution, each with its own unique culture and world view. She therefore supported the WHO traditional medicine strategy: 2014–2023, in particular in the following areas: understanding and recognizing the role and potential of traditional and complementary medicine; strengthening the knowledge base; building evidence and sustaining resources; strengthening quality assurance, safety, proper use and effectiveness of traditional and complementary medicine through the regulation of products, practices and practitioners; and exploring ways of integrating traditional and complementary medicine in national health systems and ensuring that consumers of traditional and complementary medicine made informed choices about self-health care.

Mr ZHU Haidong (China), commending the report on traditional medicine, said that increased interest in traditional medicine in recent years had elicited a growing demand, giving rise to new challenges. WHO had conducted a global survey on the status of traditional medicine since 2010, and, after analysing the information provided by 130 Member States, had convened experts, representatives of Member States and other stakeholders in order to update the strategy on traditional medicine for the period 2014–2023. The updated strategy highlighted three key objectives, six strategic directions and a range of actions; it encompassed a clearly defined process, as well as action plans and targets that should help countries to coordinate their efforts in order to respond jointly to new challenges in the field of traditional medicine. He supported the draft resolution.

Mr SILLO (United Republic of Tanzania) supported the potential role of traditional medicine in national health systems and the need for regulation of practitioners, practices and products, as well as for collaboration between practitioners of traditional and conventional medicine and protection of intellectual property rights and traditional medicine knowledge. Recognizing the potential role of traditional medicine in primary health care services, the Government of the United Republic of Tanzania had introduced legislation, including regulations and guidelines for the registration of herbal and traditional medicines. However, existing regulation and enforcement measures were inadequate and research on, and production of, traditional medicine products were hampered by insufficient human and financial resources and weak partnerships between the private and public sectors. Understanding of intellectual property rights was limited and insufficient to adequately protect traditional medicine knowledge. Such challenges could be addressed if the updated traditional medicine strategy were adapted to suit local needs and accompanied by national and regional policies based on the three objectives set out in the strategy. He supported the adoption of the draft resolution, which would facilitate the attainment of the targets set out in the updated African Regional Strategy on Traditional Medicine.

Dr DEDI KUSWENDA (Indonesia) said that 30% of the Indonesian population used traditional medicines. The Government was developing policies and regulations to ensure the safety, efficacy and quality of traditional and complementary medicines in order to address the following shortcomings: insufficient knowledge-based management of their use; inadequate regulation of practices and practitioners; limited implementation and monitoring of product regulation; and inadequate integration of traditional and complementary medicine services into national health care services. Some progress had been made, particularly in integrating traditional medicine in health services in health centres and hospitals. The Ministry of Health was working to strengthen the knowledge base and skills in herbal medicine, acupuncture and acupressure. An Indonesian herbal pharmacopoeia had been compiled and measures introduced to improve the quality of products and raw materials. While he broadly supported the updated traditional medicine strategy, it would require amendment to meet the needs and capabilities of countries. He also requested technical support for developing the knowledge base of traditional and complementary medicine.

Dr PHAM THI CHINH (Viet Nam) endorsed the updated strategy contained in document A67/26 and the draft resolution in resolution EB134.R6. Referring to subparagraph 2(1) of the draft resolution, she agreed that the updated strategy should be adapted to suit the national situation. Countries had reached different stages in the development of traditional and complementary medicine, including in the areas of policy and regulation. With regard to subparagraph 2(2), she suggested that Member States might report biennially on their progress in implementing the updated strategy. On the basis of the information gathered, the Secretariat could compile a consolidated document, perhaps every five years. The data could then be transferred to a database to which countries would have access.

Dr LOUME (Senegal), speaking on behalf of the Member States of the African Region, said that the Region had implemented several decisions to strengthen the role of traditional medicine and was pleased with their positive impact. In line with resolution AFR/RC50/R3 on promoting the role of traditional medicine in health systems: a strategy for the African Region, between 2001 and 2012, Member States of the African Region had carried out activities that aimed to promote traditional medicine by developing national policies and frameworks for its practice, practitioners and products. By 2012, 40 countries had developed traditional medicine policies and 19 had national strategic plans. Research on traditional medicine products for malaria, HIV/AIDS, sickle-cell anaemia, diabetes and hypertension was being carried out by 28 national research institutes. He welcomed the West African Health Organization's initiative to develop a training manual on those conditions that was aimed at traditional medicine practitioners.

More than 13 countries had issued marketing authorizations for traditional medicine products; seven countries had included traditional medicine products in their national lists of essential medicines; and nine countries had adopted a national framework to protect intellectual property rights and knowledge linked to traditional medicine products and practices.

Despite the progress achieved, Member States were confronted with shortfalls owing to a lack of regulation, governance and existing and applicable legal frameworks. Several regional and subregional organizations had underlined the importance of traditional medicine for Africa's development. In 2007, for example, the Economic Community of West African States had established a traditional medicine programme within the West African Health Organization.

Several practical measures should be taken to accelerate the process of implementing national traditional medicine policies and plans in Africa, and in particular the implementation of the WHO traditional medicine strategy: 2014–2023 as a basis for national programmes and work plans. He supported adoption of the draft resolution contained in resolution EB134.R6.

Mr DENEKEW (Ethiopia) acknowledged the value of the updated strategy and agreed to work closely with the Secretariat to strengthen knowledge, skills and sustainable use in relation to traditional medicine. In addition, efforts would be made to achieve universal health coverage through improved delivery of health services, and particularly of primary health care. Closer collaboration was also needed in the setting up and strengthening of systems and capabilities in relation to standardization, integration and regulation of traditional medicine.

Dr NITHIMA SUMPRADIT (Thailand) welcomed the WHO traditional medicine strategy: 2014–2023 and the draft resolution contained in resolution EB134.R6. However, although the strategy emphasized traditional medicine used or provided by health systems, there was evidence that traditional healers, including herbalists, monks or priests, who offered services outside conventional health service settings, continued to play an important role in primary health care in many countries, especially in rural communities. Their contribution to community health care should not be ignored. The proper education, training, assessment and licensing of traditional healers should therefore be a strategic action, in line with country contexts, to ensure the quality, safety and efficacy of their services.

As a monitoring framework and indicators were important in order to measure the progress of traditional medicine over the next decade, she proposed that the phrase “and the importance of key performance indicators in guiding the evaluation of the advancement over the next decade” should be added at the end of paragraph 1 of the draft resolution.

Dr KISAKA (Japan) welcomed the WHO traditional medicine strategy: 2014–2023 and fully supported the draft resolution contained in resolution EB134.R6. She believed that the integration of proper traditional medicine knowledge and skills by Member States into their health systems would be effective, provided that efficacy and safety were assured. At the same time, further research and evidence in traditional medicine needed to be built up, and she requested and expected strong engagement from WHO in that regard. Japan’s knowledge of traditional medicine, including its studies on “integrative medicine” to investigate possible policies and approaches for promoting traditional medicine’s integration into modern medicine, could be useful to Member States implementing the WHO traditional medicine strategy: 2014–2023.

Dr ALSALEH (Kuwait) supported the WHO traditional medicine strategy: 2014–2023 and the key objectives of the WHO traditional medicine strategy: 2002–2005, which dealt with policy; safety, efficacy and quality; access; and rational use. He was aware of the challenges for traditional and complementary medicine and wished to focus on research and development. A new methodology for traditional and complementary medicine should be initiated in parallel with orthodox medicine. Kuwait was developing guidelines for traditional and complementary medicine, in collaboration with the countries of the Gulf Cooperation Council, and would adopt a law on traditional and complementary medicine before the end of 2014.

Ms CHASOKELA (Zimbabwe) supported the draft resolution contained in resolution EB134.R6. She drew attention to the need to protect intellectual property rights in relation to traditional medicine.

Mr COTTERELL (Australia) was pleased to sponsor the draft resolution contained in resolution EB134.R6 and thanked the delegation of China for its leadership in developing it. He appreciated the inclusion of text recognizing differing national capacities, legislation and circumstances, and looked forward to contributing to implementation of the updated WHO traditional medicine strategy: 2014–2023.

Ms GARCÍA ARREOLA (Mexico) supported the WHO traditional medicine strategy: 2014–2023, noting in particular its strategic objective 2 on strengthening quality assurance, safety, proper use and effectiveness of traditional and complementary medicine by regulating its related products. As part of a group established in 2006 by WHO to promote international regulatory collaboration, Mexico was committed to continued collaboration with the Organization in the area of safe regulation of herbal medicines. She proposed to continue to study traditional medicine and to recognize it as a complete system of health care; to recognize the knowledge, methods, practices and contribution to health of practitioners in each country; to guarantee intercultural relations and mutual enrichment between health system staff and traditional medicine practitioners; to recognize the need to support traditional medicine practitioners to develop their own processes for recapturing and handing on knowledge; to promote the sustainable development of traditional medicine; and to incorporate traditional medicine products into the list of essential medicines.

Dr REDDY (India) said that India was happy to sponsor the draft resolution contained in resolution EB134.R6, which was an important step in the development of traditional medicine in different parts of the world and rightly urged Member States to adopt, adapt and implement, where appropriate, the WHO traditional medicine strategy: 2014–2023. India had a rich heritage of traditional medicine systems, many of which were popular and widely used and recognized by the

Government. India had vast resources of medicinal plants and extensive knowledge of traditional medicine. Many Member States of the South-East Asia Region, including India, had practised traditional and complementary medicine through the ages and had extensive traditional and complementary medicine systems within existing health services, as well as national policies and regulations.

The Delhi Declaration on Traditional Medicine, adopted in 2013, promoted cooperation, strategic collaboration and the development of a harmonized approach among South-East Asian countries in relation to traditional medicine. He hoped that adoption and implementation of the draft resolution would give a boost to traditional medicine and implementation of the WHO traditional medicine strategy: 2014–2023.

He proposed the following amendments to the draft resolution: in the third preambular paragraph, the word “effectiveness” should be inserted after the phrase “Affirming the growing importance”; in subparagraph 2(2), the words “as appropriate” should be inserted after the phrase “to report to WHO”; and in subparagraph 3(1), the words “upon request” should be inserted after the words “to facilitate”. The phrase “and allocate appropriate funds towards” should be inserted after the words “to monitor” in subparagraph 3(4), while subparagraph 3(5) should be amended to read: “to report to the World Health Assembly every three years, through the Executive Board, on progress made in implementing this resolution”.

The meeting rose at 12:20.

THIRD MEETING

Thursday, 22 May 2014, at 14:35

Chairman: Dr S. AKAUOLA (Tonga)

HEALTH SYSTEMS: Item 15 of the Agenda (continued)

Traditional medicine: Item 15.1 of the Agenda (Documents A67/26 and EB134/2014/REC/1, resolution EB134.R6) (continued)

Dr DAKULALA (Papua New Guinea) welcomed the updated WHO traditional medicine strategy: 2014–2023. The centuries-long practice of traditional medicine in his country was gradually becoming lost. With its vast biodiversity, his country could well provide the ingredients for new medicines and cures; in that context, it was important to address intellectual property concerns in order to help Papua New Guinea to harness its potential. He supported the draft resolution recommended by the Executive Board in resolution EB134.R6.

Mr LEWIS (Canada) said that his country wished to be included among the sponsors of the draft resolution.

Ms SITI AIDA ABDULLAH (Malaysia) noted the expected outcomes of the revised strategy and supported the proposed key performance indicators. She looked forward to the professionalization of the field of traditional medicine and its global recognition as an important component of health care.

Mr KIM Young-hak (Republic of Korea) said that if traditional medicine were to be successfully integrated into national health care systems, credible surveys of its use and reliable scientific evidence of its safety and efficacy would be required, and stakeholder interests would need to be protected. Countries should share their experiences of integrated traditional and western health care models. The Secretariat should provide technical support to Member States through traditional medicine specialists based at its regional offices.

Mr KOLKER (United States of America), acknowledging the leadership of China in traditional medicine, expressed his approval of the revised strategy, which recognized the importance of evidence-based medicine, research, and regulatory and quality assurance guidelines and standards. India's proposed amendment to the second preambular paragraph, relating to the effectiveness of traditional medicine, was inappropriate: he preferred the original wording. The proposed amendment regarding allocation of funding for the implementation of the strategy was also inappropriate: any reference to funding would imply that WHO's traditional medicine strategy took precedence over its other work.

Dr TSESHKOVSKY (Russian Federation) said that his Government was working with the Russian professional association for traditional medicine practitioners. It had made progress in regulating the use of herbal medicines and had adopted a law to regulate practitioners. The WHO strategy provided useful guidelines for countries to follow when developing national policies and standards in traditional medicine. He supported the draft resolution with the proposed amendments.

Dr A. PILLAY (South Africa) said that his country had established national and provincial traditional medicine units that disseminated information to practitioners, enabling them to update their practices. University and government departments were active in research and development in the field of traditional medicine. The Government was preparing to regulate traditional medicine products, and a council to regulate the activities of practitioners would be established, as had been done for other health professions. Traditional medicine was to be integrated into primary health care programmes.

Dr ASSIH (Togo) said that the inclusion of traditional medicine in Togo's public health legislation and the celebration of African Traditional Medicine Day had helped to raise its profile. Progress had been achieved through Togo's technical support group on traditional medicines and by advocacy efforts to speed up the regulation of traditional medicines and establish a standard procedure for marketing authorizations. However, much remained to be done to integrate traditional medicine effectively into the health system, to develop policies based on the WHO strategy and to improve the skills of practitioners. She supported the draft resolution.

Dr TIN THITSAR LWIN (Myanmar) said that traditional medicine was particularly important for rural dwellers. The Secretariat should provide further details showing how the proposed knowledge base would be shared among Member States. She asked what technical support the Secretariat could provide in relation to quality assurance, safety and effectiveness of traditional medicines. She called on the Secretariat to increase human and financial resources and technical support at headquarters and in regional offices for the regulation of traditional medicines.

Mrs IRO (Cook Islands) said that, in the past, traditional medicine practitioners had passed their knowledge on informally to a chosen successor. As traditional medicine practitioners had been legally recognized as allied health professionals, they had to be subject to regulation. It would take time for practitioners to establish their own regulatory association and appreciate the benefits of being part of the national health system.

Dr GYANSA-LUTTERODT (Ghana) said that traditional medicines had been regulated by Parliament, and a number of herbal medicine practitioners were trained at university level. The Traditional Medicine Practice Council regulated the activities of practitioners, while the Food and Drugs Authority regulated medicinal products.

Dr MACKIE (New Zealand) supported the draft resolution.

Mr PAK Jong Min (Democratic People's Republic of Korea), speaking on behalf of the Member States of the South-East Asia Region, said that many governments in the Region had incorporated traditional medicine into their national health care systems and already had their own policies and regulations. The Regional Office for South-East Asia had helped to ensure that traditional medicine was used safely and effectively. Under the 2013 Delhi Declaration on Traditional Medicine, South-East Asian countries had agreed to cooperate and support each other in all areas relating to traditional medicine. Other regions could learn from such a harmonized approach. He urged the Secretariat to allocate appropriate technical and financial resources to implementation of the new strategy.

Mrs OKPESEYI (Nigeria) said that the strategic plan for implementation of Nigeria's traditional medicine policy had been developed in collaboration with the Secretariat. The National Assembly had yet to adopt a proposed law on traditional medicine regulation, and no traditional medicine products were yet included on the national essential medicines list.

Ms VALLINI (Brazil) noted the economic importance of traditional medicine. There was a growing interest in traditional medicine throughout the world, but there were considerable differences in levels of training and accreditation. It was important to protect data and rights and to recognize the traditional knowledge of indigenous communities.

The new WHO strategy was a step forward and would stimulate the regulation of traditional medicine practices and products.

Dr JAFARIAN (Islamic Republic of Iran) said that traditional medicine was regulated in his country and taught as a specialty at several prestigious universities. Traditional medicine should be integrated into health care provision, particularly primary health care. He supported the draft resolution but suggested that an amendment should be added at the end of the fourth preambular paragraph along the following lines: “with the ultimate goal of living healthily and being a good human being”. The draft resolution should also reflect the fact that traditional medicine might be misused or overused.

Dr Yi-Tsau HUANG (Chinese Taipei) described the extensive use of traditional medicine in Chinese Taipei, including the regulation of traditional medicine products and practice, university-level training, health insurance coverage for outpatient treatment, good manufacturing practices, clinical trials and a pharmacopoeia. Chinese Taipei would willingly share its experiences with Member States.

Dr KIENY (Assistant Director-General) noted the many expressions of interest in knowledge sharing and technical support, and said that the Secretariat would be happy to respond to any Member State that contacted it.

The CHAIRMAN invited the Committee to consider the draft resolution contained in resolution EB134.R6, with the proposed amendments.

Mr KOTALWAR (India) withdrew his suggestion that the word “effectiveness” should be added in the second preambular paragraph, in the interests of consensus.

The CHAIRMAN suggested that the Secretariat should prepare a draft showing the proposed amendments, to be considered at a later meeting.

It was so agreed.

(For resumption of the discussion, see page 273.)

Follow-up of the report of the Consultative Expert Working Group on Research and Development: Financing and Coordination: Item 15.2 of the Agenda (Documents A67/27, A67/28 and A67/28 Add.1)

Ms DUSSEY-CAVASSINI (Switzerland) noted the tangible progress made in the health research and development demonstration projects described in document A67/28 and approved of the indicators chosen to measure their success. She expressed support for the proposed pooled fund to support all four projects. The fund would show how funding for health research and development might be coordinated in the future. The Government of Switzerland was prepared to make a considerable contribution to the fund. She expected the Secretariat to allocate funds from the regular budget, to demonstrate its commitment to the ideas highlighted in the report of the Working Group (document A65/24, Annex). Other Member States should also contribute financially, particularly emerging and industrialized countries and those that would benefit most from the demonstration projects.

Ms NAULEAU (France), having consulted other delegates, proposed that a draft decision should be prepared, stating that the Health Assembly welcomed the progress made in implementation of resolution WHA66.22 and decision EB134(5); endorsed the indicators to measure success in implementing the health research and development demonstration projects; requested the Director-General to expedite the process in respect of the remaining four projects, in addition to the four already agreed, and to report progress to the Executive Board at its 136th session; and noted, among other options, the assessment of the possibility of using an existing mechanism to host a pooled fund for voluntary contributions towards research and development for diseases that disproportionately affected developing countries, and requested the Director-General to further explore the option with the UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases, take appropriate action and submit a report to the Sixty-eighth World Health Assembly.

Dr SHOHANI (Iraq) highlighted the importance of research and development. It was necessary to establish strategic objectives and priorities for primary and secondary health care, to make systems effective and to ensure health care coverage in all countries. The work of ministries of education and health needed to be improved. Ministries of health needed a clear plan of action to meet national health needs and a research and development plan to strengthen primary health care.

Mr KOUYATÉ (Burkina Faso), speaking on behalf of the Member States of the African Region, said that recent regional consultations had shown that Member States were in favour of the new Global Observatory. For the African Region, it was imperative to choose an appropriate coordination mechanism quickly, since most of the people suffering from the diseases in question lived in Africa. More effort was needed to create a transparent funding mechanism, such as the pooled fund mentioned by the delegate of France, which would put research and development on a sound footing.

Dr LAHTINEN (Finland), speaking on behalf of the Member States of the European Region, encouraged the Secretariat and Member States to gather relevant information to fill the gaps in the Global Observatory knowledge base. He welcomed the four selected demonstration projects and the indicators proposed by the Secretariat to measure their success. The expected outcome of the demonstration projects should be that alternative and innovative financing and coordination models had been launched with specific deliverables in the form of new, affordable health products. Although it would only be possible to assess the process, rather than the longer-term outcomes, over the next year, the Secretariat should nevertheless report to the Sixty-eighth World Health Assembly on the progress made. He favoured the use of an existing mechanism, the Special Programme for Research and Training in Tropical Diseases, to manage financial contributions for research and development. The Secretariat should assess that option and provide feedback to Member States before the 136th session of the Executive Board.

Dr JARUAYPORN SRISASALUX (Thailand) called for a participatory approach to engage researchers and institutions in the development of the Global Observatory. Thailand had recently established its own national research repository where researchers could share their data with others, which was useful for monitoring national progress in health research and development.

Ms SAMIYA (Maldives) said that support for building capacity at country level might be required in order to enable countries to both contribute information to and benefit from the Global Observatory. The dedicated budget line opened for the demonstration projects within the Trust Fund of the Special Programme for Research and Training in Tropical Diseases was an encouraging development. Although her Government acknowledged the progress that had been made, it would like to see the speedy establishment of a concrete coordination and financing mechanism to help meet the health research and development needs of developing countries.

Mr QASEM (Jordan) said that his Government had adopted strategies for action on health priorities established in collaboration with WHO: to improve training and capacity for research, and to develop human and financial resources. Jordan needed better coordination between ministries, universities and research institutions. National ministries that lacked the capacity to carry out the necessary health research to improve services should cooperate with WHO to develop their capacity.

Dr MALECELA (United Republic of Tanzania) said that it was unclear how the Global Observatory would ensure engagement at regional and country levels. The lack of a research and development coordination mechanism perpetuated a system that did not provide sufficient funding for priority problems for African countries: that mechanism should preferably be affiliated with WHO and should not await the outcome of the demonstration projects. In addition to the demonstration projects, the Secretariat should examine other models that would spur innovation, and the substantial funding for the demonstration projects must support capacity-strengthening. The partnerships behind the demonstration projects, while laudable, still reflected the existing North-South research dichotomy; moreover, the project proposals did not exhibit country ownership or a strong country base. The discussion on research and development financing did not provide clarity. Emerging and developed countries should contribute to the fund for research and development into diseases disproportionately affecting developing countries, as change would only come about with multiple committed sources of funding.

Mr KOTALWAR (India) said that India had submitted three demonstration project proposals, one of which, despite being named as the second-best project at an earlier stage, was not one of the four projects finally selected. The Secretariat should support not only four but all eight shortlisted projects. In the light of the significant public health impact and the scientific and technical merits of the project submitted by India on a multiplexed point-of-care test for acute febrile illness, the Secretariat should consider it, as well as the other projects, at the next stakeholders' meeting.

Dr A. PILLAY (South Africa) said that the demonstration projects should be implemented with improved financing and coordination. He expressed support for the proposed indicators and the draft decision proposed by France. The Secretariat should expedite the implementation of all the demonstration projects, not merely the four selected ones, and should discuss the possibility of establishing a voluntary pooled fund with the Special Programme for Research and Training in Tropical Diseases. Funding should not be confined to Type III diseases. Special emphasis should be placed on funding for the Global Observatory.

Mr KIM Young-hak (Republic of Korea) said that before the Global Observatory could be fully established, clear standards would need to be set for the scope, collection and sharing of information, taking into account the different monitoring situations and the research and development resources of each country.

Existing and new mechanisms for handling contributions to health research and development had been sufficiently assessed. However, the goals and mission of each mechanism would need to be reviewed before one was chosen. The key to success would be to expand joint research and build cooperative networks with businesses and research institutes, in order to provide practical health support for developing countries.

Ms BURRIS (United States of America) supported the draft decision proposed by France. One goal of the projects should be to create ways for new, non-traditional donors to contribute; her country therefore supported the formation of a voluntary pooled funding mechanism within the Special Programme for Research and Training in Tropical Diseases. She supported the proposed indicators presented as initial milestones for success, although more would be needed in the coming years.

It was hoped that the projects would use innovative platforms in order to share knowledge and build partnerships across different sectors, including health foundations, the private sector and

academia and that, under the guidance of WHO, the projects would benefit from that inclusive approach.

Mrs NAARENDORP (Suriname), speaking on behalf of the Union of South American Nations, said that Member States and independent experts had recognized that alternative models of health research and development were required that de-linked the cost of research and development from the cost of health products and ensured that they were more closely aligned with health priorities.

It would be important for the Global Observatory to become not only a data repository but also a facility for knowledge management and the promotion of information exchange. The coordination models identified by the Secretariat should accord a more prominent role to Member States: existing funding mechanisms did not meet the required criteria for sustainability, predictability and governance. The proposal that the Special Programme for Research and Training in Tropical Diseases should host the funding mechanism was a matter of concern; it would be important to ensure that its mandate was not limited to Type II diseases.

In addition to the selected demonstration projects, regions, countries and organizations should continue with their own initiatives and contribute to the design of de-linked research and development models, focused on innovation and based on open and collaborative sources, and coordination and funding mechanisms that were efficient and cooperative. The results of the partial evaluations of the demonstration projects should not affect continuing discussions under resolution WHA66.22.

Dr PANGESTI (Indonesia) said that the demonstration projects should include mechanisms to ensure access to and affordability of health products in all countries. Indonesia had contributed to a regional strategic work plan for a regional research and development observatory, and was setting up its own. She hoped that WHO would provide or mobilize technical assistance to develop research and development classification systems and observatories.

Mr KLEIMAN (Brazil) said that the demonstration projects, which had been selected in a legitimate and transparent process, should be fully implemented once their innovative aspects, technical and scientific merit, and public health significance had been evaluated. Brazil would contribute financially to the implementation of the selected projects. It further supported the initiative of the Secretariat to offer technical support for implementation of the projects and was ready to host a meeting with stakeholders in August 2014 in order to move to implementation as soon as possible.

Concerning the Global Observatory, he underlined the importance of a mechanism that could identify opportunities for health research and development and analyse information on available global funding: PAHO's Regional Platform for Access to Health Technologies and Innovation could perhaps serve as a model in that regard.

He agreed that existing funding mechanisms should be consulted about the coordination of health research and development, particularly in respect of the criterion of adaptability.

Ms GARCÍA ARREOLA (Mexico) said that Mexico would submit information to the Global Observatory with a view to promoting the exchange of statistical data that would in time improve access to comparable information and identify national and regional research and development priorities to assist in decision-making. It would be necessary to coordinate health research and development through more efficient information-sharing and collaborative research networks that would set joint priorities and manage research and resource allocation.

Dr TSESHKOVSKY (Russian Federation) acknowledged the importance and relevance of health research and development, in particular for developing countries. The Russian Federation welcomed the creation of the Global Observatory, since it would allow sharing of a broad spectrum of scientific research and evaluation and selection of funding mechanisms. His country supported the current mechanism for the creation of a voluntary pooled fund for research and development and welcomed the selected demonstration projects and the indicators chosen to measure success in the

process, rather than the final outcomes, since scientific research was a lengthy process that rarely produced quick results.

Mr ZHU Haidong (China) welcomed the establishment of the Global Observatory and the exploration of coordination mechanisms that would be useful in helping countries to exchange information, identify priorities and promote cooperation. It would also be useful for evaluating trends in financing of research and development around the world. An effective contribution mechanism would be very important in order to channel funds to diseases that had a particular impact on developing countries. The proper functioning of the Global Observatory would depend on the exchange of data at national, regional and global levels. Particular emphasis should be placed on innovative global funding mechanisms and the rapid compilation of criteria with which to assess the mechanisms. Existing global mechanisms should be used for pooling of funds and the mechanisms chosen should be those that most closely met the assessment criteria. China supported the managed coordination model described in paragraph 12 of document A67/27. It also supported the establishment of a new global advisory body that would take into account the views of all stakeholders and provide impartial recommendations.

Dr SHAHANIZAN MOHD ZIN (Malaysia) said that her country would offer technical expertise at future stakeholder and consultative meetings and explore the possibility of participating in some projects, such as those on the development of medicines to treat diseases of poverty and neglected diseases and the development of vaccines against malaria and dengue.

Ms PACHECO RODRIGUEZ (Plurinational State of Bolivia) said that, while supporting the report, her delegation wished to see more in-depth discussion and analysis of the themes it contained. In follow-up to the report, the recommendations of the Working Group and the mandate contained in the global strategy and plan of action on public health, innovation and intellectual property should be respected, with a focus on research and development for Type II and Type III diseases, as well as Type I diseases in developing countries, and the formulation of innovative models that allowed the costs of research and development to be de-linked from the price of medical products. A new global framework for coordination and financing of research and development that included the full participation of Member States would be required. The Working Group had indicated that existing mechanisms could be used as the basis for the creation of a new research and development advisory body. The new funding mechanism chosen should meet all of the recommendations set out by the independent experts: to disburse funds to public and/or private entities to finance research into diseases affecting developing countries; to support all phases of the research and development process; to generate research capacity in developing countries; and to promote technology transfer.

While expressing appreciation for the reports on demonstration projects (documents A67/28 and A67/28 Add.1), she emphasized that it should not prejudge the outcome of the work set out in resolution WHA66.22.

Mr PIPPO (Argentina) said that, in order to acquire the information that would enable the Global Observatory to reflect the situation in Member States accurately, consideration should be given to the collection of specific and methodologically homogenous data. The role of the Global Observatory would be important in generating a systemic overview, with the participation of Member States in defining health priorities based on public health needs within the framework of the global strategy and plan of action on public health, innovation and intellectual property.

While welcoming the proposals for coordination mechanisms, the possible organizational structure for a funding mechanism and indicators to measure success, he emphasized that mechanisms adopted to carry out the functions of information monitoring, prioritization, coordination and financing of health research and development should be considered not in isolation but as forming part of the same strategy, following the same principles and subject to the same governance. The possible organizational structures described in document A67/27 represented a first draft that should be further

discussed by Member States with the support of the Secretariat. The structures should be effective and form part of a single strategic framework in which the various components would be clearly distinguished.

All eight of the demonstration projects should be implemented. It was appropriate to identify indicators to measure the process rather than the outcome at the present stage: further indicators should be added to show innovative features of research and development and aspects related to coordination and financing. Member States should be informed about the process by which they would participate in governance of the projects. He asked whether the scope of the Special Programme for Research and Training in Tropical Diseases, which currently dealt with diseases associated with poverty, would be expanded to include diseases covered by the global strategy and plan of action on public health, innovation and intellectual property.

Dr JAFARIAN (Islamic Republic of Iran), while welcoming the reports and the work accomplished, requested the provision of documents that were more oriented towards health systems. They should take into consideration health financing, human resources for health, universal health coverage, approaches to public health based on social determinants, health governance at local level and evidence-based policy-making and utilization. Strengthening health systems, avoiding a vertical approach to health, considering a “health in all policies” approach and following the rules of healthy policy-making should be at the heart of all measures to achieve a healthy population, which was the main goal of health system research and innovation.

Dr MPOKE (Kenya) welcomed the four demonstration projects and the idea of a global observatory, although more details would be required about how the Observatory would function and, in particular, how it would acquire the relevant information on research and development. Kenya had recently enacted legislation relating to science, technology and innovation with a commitment to research and development. It would consider contributing finances to the demonstration projects through the pooled mechanism.

Dr NGIGE (Nigeria) supported the recommendations concerning financing and coordination made by the Working Group. As a developing African nation, Nigeria recognized health as a cornerstone of government policy; it had set up one medical and one pharmaceutical research institute, since training and research were the foundations for improvements in health.

Although economic and security conditions and the paucity of funds had affected health research in his own country, the proposals by the Working Group for sharing of information, active coordination and managed coordination were encouraging. No single mechanism would meet all needs; a hybrid approach, combining the “active” and “managed” options, was a possibility. However, the creation of new funds envisaged under managed coordination would do a great deal to open up the product pipeline for neglected tropical diseases.

Dr Yi-Tsau HUANG (Chinese Taipei) said that, responding to the need for capacity-building, technology transfer and investment in health research and development for diseases disproportionately affecting developing countries, Chinese Taipei was ready to share its experiences and achievements and provide developing countries with training and funding, as well as vaccines, diagnostics and medicines.

Ms ATHERSUCH (MSF International), speaking at the invitation of the CHAIRMAN, reiterated the urgent need for countries to put in place a sustainable global framework that would comprehensively address the persistent research and development challenges posed by diseases affecting developing countries. With many health products unavailable, unsuitable or unaffordable, the problem directly affected the work of MSF International.

She strongly urged Member States to pursue the “managed” option for coordination of health research and development, since linking priority-setting to funding would increase the impact of the coordination mechanisms, which would otherwise be very limited.

Two proposals for a pooled fund were available for consultation on the WHO website; one by the African Network for Drugs and Diagnostics Innovation and one by the Special Programme for Research and Training in Tropical Diseases. More analytical work was needed to explore concrete options for funding mechanisms that responded to all the recommendations of the report contained in document A67/27. Funding must be made available for research and development proposals that fully implemented de-linkage and met the priority needs of developing countries. The fund should be based on mandatory contributions from Member States, which should be actively involved in its design.

She cautioned against the proposal to limit the application of the Working Group’s recommendations to low-income countries, since around 70% of the world’s poor lived in middle-income countries. Based on the Working Group’s recommendations and the mandate of the global strategy and plan of action on public health, innovation and intellectual property, any mechanisms created should stimulate research and development related to Type II and Type III diseases, as well as to the specific needs of developing countries in relation to Type I diseases.

Mr BALASUBRAMANIAM (Stichting Health Action International), speaking at the invitation of the CHAIRMAN, called on WHO to begin negotiations on a global treaty creating a new mechanism to set global norms for health care research, including sustainable sources of funding. Member States were encouraged to expand the scope of the Working Group’s proposals to address additional funding for research on the development of new antibiotics and better low-cost diagnostics, basic research in areas of particular interest to all Member States, and independent clinical trials to evaluate the efficacy of pharmaceutical medicines.

The work on demonstration projects had got off to a promising start, with many innovative funding proposals. Unfortunately, the Global Technical Consultative Meeting of Experts had eliminated all proposals to create innovative funding mechanisms and had simply recommended grants for research on specific problems. Those grants were important, but hardly novel, and they did not demonstrate anything new about funding approaches. The Secretariat wanted to create a new pooled funding mechanism, but it should explain why the proposal had not been subject to the same review as the other demonstration projects, and how it fitted into the longer-term objective of creating global mechanisms.

Ultimately, it would be necessary to address the issues raised by the Director-General relating to trade negotiations that created barriers to the supply of affordable medicines. WHO should see the research and development negotiations on de-linkage of research and development costs from prices as an alternative paradigm.

Mr TCHOLAKOV (International Federation of Medical Students’ Associations), speaking at the invitation of the CHAIRMAN, said that medical innovations that were not tied to profit were crucial for future health workers such as his organization’s members.

Long-term sustainability was needed in the financing of health research. Indirect taxation could provide sustainable funding commitments, while the proposed solidarity tobacco contribution would both raise revenue and contribute to the prevention of noncommunicable diseases. He commended the demonstration project entitled “The Visceral Leishmaniasis (VL) Global R&D & Access Initiative” and was pleased that most of the demonstration projects included clear commitments to open licensing and access-focused intellectual property management for end-products. The use of traditional grant funding might not advance the goal of sustainable financing.

Dr KIENY (Assistant Director-General) said that she was grateful to Member States and civil society actors for their comments on the reports, and in particular to the delegations of Brazil, France, Kenya and Switzerland for their offers of financial support for the demonstration projects and the Global Health Research and Development Observatory.

She thanked Member States for their support for the monitoring framework proposed by the Secretariat and noted the request by France, India and others to expedite the process in respect of the remaining four demonstration projects. She wished to stress that the remaining projects had not been selected as they did not match the characteristics of true demonstration projects as defined by the Working Group report and endorsed by Member States during Executive Board sessions. The Secretariat, with the support of Brazil, would provide expert advice to the sponsors of the projects and help them to revise the design where possible. Work would soon begin on the projects that had already been selected. She was concerned by the paucity of funding available for implementation of those projects, for which only a small proportion of the US\$ 50 million required had been found. She asked Member States to provide financial support for that important process.

She noted the request for the Secretariat to enter into discussions with the Special Programme for Research and Training in Tropical Diseases in order to define more specifically the proposals in terms of governance and implementation mechanisms for a possible new voluntary pooled fund. The Special Programme had already provided assurances that the fund would not be restricted to infectious diseases of poverty, but would cover the full scope of the global strategy and plan of action on public health, innovation and intellectual property.

Work was continuing on the Global Observatory, and Member States were invited to continue discussion of its characteristics with the Secretariat. With the possibility of a new fund hosting the funding mechanisms, coordination of health research and development promised to be even more effective. Further discussion of the recommendations of the Working Group was planned for the last trimester of 2015, in preparation for the Sixty-ninth World Health Assembly in 2016.

The Committee noted the reports contained in documents A67/27, A67/28 and A67/28 Add.1.

The CHAIRMAN recalled that several delegations had asked for the preparation of a draft decision on the present item.

Ms PACHECO RODRIGUEZ (Plurinational State of Bolivia), supported by Dr ELOAKLEY (Libya), Mr PIPPO (Argentina), Mrs NAARENDORP (Suriname), Ms GARCÍA ARREOLA (Mexico) and Mr AL-ABDULLA (Qatar), requested that the draft decision be put in writing and distributed in the working languages of the Organization for the consideration of delegations.

The CHAIRMAN suggested that any interested delegations could participate in informal consultations with the delegations of France and Switzerland in order to agree on the text of a decision that could be presented to the Committee.

Mr COTTERELL (Australia) asked whether the draft decision added any information that was not to be found in resolutions and decisions that had already been published.

Mr SOLOMON (Office of the Legal Counsel) said that, as there was some uncertainty on the content of the draft decision, it would be preferable to issue it in written form before asking delegations to indicate their position.

The CHAIRMAN took it that the Committee agreed to suspend consideration of the item.

It was so agreed.

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

Traditional medicine: Item 15.1 of the Agenda (Documents A67/26 and EB134/2014/REC1, resolution EB134.R6) (resumed)

The CHAIRMAN proposed that amendments to the draft resolution contained in resolution EB134.R6 should be read out.

Mr COTTERELL (Australia), supported by Ms REITENBACH (Germany) and Dr NITHIMA SUMPRADIT (Thailand), asked for the amendments to the draft resolution to be published and translated.

The CHAIRMAN suggested that consideration of the item should be suspended pending the preparation of a conference paper showing the proposed amendments.

It was so agreed.

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

The meeting rose at 17:00.

FOURTH MEETING

Friday, 23 May 2014, at 09:35

Chairman: Dr R. RUGUNDA (Uganda)

later: Dr S. AKAUOLA (Tonga)

1. SECOND REPORT OF COMMITTEE B (Document A67/69)

Dr SINGH (Nepal), Rapporteur, read out the draft second report of Committee B.

The report was adopted.¹

2. HEALTH SYSTEMS: Item 15 of the Agenda (continued)

Traditional medicine: Item 15.1 of the Agenda (Documents A67/26 and EB134/2014/REC/1, resolution EB134.R6) (continued from the third meeting)

The CHAIRMAN invited the Committee to resume its consideration of the draft resolution contained in resolution EB134.R6, which had been amended as follows:

The Sixty-seventh World Health Assembly,

PP1 Recalling resolutions WHA22.54, WHA29.72, WHA30.49, WHA31.33, WHA40.33, WHA41.19, WHA42.43, WHA44.34, WHA54.11, WHA56.31, WHA61.21, and in particular WHA62.13 on traditional medicine, which requested the Director-General, inter alia, to update the WHO traditional medicine strategy 2002–2005, based on countries' progress and current new challenges in the field of traditional medicine;

PP2 Affirming the growing importance and value of traditional and complementary medicine in the provision of health care nationally and globally, and that such medicines are no longer limited exclusively to any particular regions or communities;

PP3 Noting the heightened level of interest in aspects of traditional and complementary medicine practices and in their practitioners, and related demand from consumers and governments that consideration be given to integration of those elements into health service delivery **with the ultimate goal of living healthily and being a good human being [Iran (Islamic Republic of)]**;

PP4 Noting also that the major challenges to the area of traditional and complementary medicine include deficiencies in: knowledge-based management and policy, appropriate regulation of practices and practitioners; monitoring and implementation of regulation on products; and appropriate integration of traditional and complementary medicine services into health care service delivery and self-health care,

(OP.1) TAKES NOTE of the WHO traditional medicine strategy: 2014–2023, its three objectives, and the relevant strategic directions and strategic actions that guide the traditional

¹ See page 349.

medicine sector in its further development and **the importance of key performance indicators in guiding the evaluation of [Thailand]** advancement over the next decade;

(OP.2) URGES Member States, in accordance with national capacities, priorities, relevant legislation and circumstances:

(OP2.1) to adapt, adopt and implement **working plans in order to integrate traditional medicine into the health services especially for primary health care services [Iran (Islamic Republic of)]**, and where appropriate, the WHO traditional medicine strategy: 2014-2023 as a basis for national traditional and complementary medicine programmes or work plans;

(OP2.2) to report to WHO, **as appropriate, [India]** on progress in implementing the WHO traditional medicine strategy 2014–2023;

(OP.3) REQUESTS the Director-General:

(OP3.1) to facilitate, **upon request, [India]** Member States' implementation of the WHO traditional medicine strategy: 2014–2023, supporting their formulation of related knowledge-based national policies, standards and regulations, and strengthening national capacity-building accordingly through information sharing, networks and training workshops;

(OP3.2) to continue to provide policy guidance to Member States on how to integrate traditional and complementary medicine services within their national and/or subnational health care system(s), as well as the technical guidance that would ensure the safety, quality and effectiveness of such traditional and complementary medicine services **with emphasis on quality assurance [Iran (Islamic Republic of)]**;

(OP3.3) to continue to promote international cooperation and collaboration in the area of traditional and complementary medicine in order to share evidence-based information, taking into account the traditions and customs of indigenous peoples and communities;

(OP3.4) to monitor **and allocate appropriate funds in accordance with the WHO programme budget towards [India and USA]** the implementation of the WHO traditional medicine strategy: 2014–2023;

(OP3.5) to report to the ~~Seventy-second~~ **[India]** World Health Assembly **every three years [India]**, through the Executive Board, on progress made in implementing this resolution.

Mr COTTERELL (Australia) proposed that the amendment by the delegation of the Islamic Republic of Iran to the third preambular paragraph of the draft resolution should be further amended to read: “with the aim of supporting healthy living” and that the amendment by the delegation of Thailand to paragraph (OP.1) should be amended to read: “... the importance of key performance indicators in guiding the evaluation of the implementation of the strategy over the next decade”. The amendment by the delegation of the Islamic Republic of Iran to subparagraph (OP2.1) could be inserted in a new subparagraph, which would read: “to develop and implement, as appropriate, working plans to integrate traditional medicine into health services, particularly primary health care services”. The amendment proposed by the delegation of the Islamic Republic of Iran to subparagraph (OP2.1) would then be removed. The words “as appropriate” should be deleted from subparagraph (OP2.2).

Mr AL KALBANI (Oman) agreed with the proposed amendments and suggested that the word “and complementary” should be inserted after the word “traditional”.

Dr JAFARIAN (Islamic Republic of Iran) said that he had some misgivings concerning the reference to complementary medicine since there was not always sufficient evidence to support its integration in primary health care. However, having considered an explanation by Mr AL KALBANI (Oman) that the reference already existed in the second preambular paragraph, he declared himself ready to accept that change.

Mr COTTERELL (Australia) agreed with the suggestion by the delegate of Oman. Noting that WHO reform efforts had attempted to relieve the reporting burden, he recommended that the words “every three years”, proposed by the delegation of India in subparagraph (OP3.5), should be replaced by the words “as appropriate”.

Dr NITHIMA SUMPRADIT (Thailand) said that it was important to include a requirement for regular reporting.

Mr COTTERELL (Australia) gave assurance that the intention of his recommendation was not to remove the obligation that the Director-General should report to the Health Assembly but to allow some flexibility in the timing of reports.

Mr ZHU Haidong (China) fully supported the recommendation by the delegate of Australia.

The CHAIRMAN asked for clarification on the legal implications of the amendments.

Mr SOLOMON (Office of the Legal Counsel) said that the Health Assembly, in resolution WHA67.2, had decided that progress reports would henceforth be considered only by the Health Assembly; consequently, it would be possible to delete the words “through the Executive Board” from subparagraph (OP3.5) of the draft resolution. He proposed that any reporting requirements should be time limited and should correspond to the time frame of the WHO traditional medicine strategy: 2014–2023.

Mr COTTERELL (Australia) supported the suggestion to remove the reference to the Executive Board. Since the traditional medicine strategy would run for a period of 10 years, a mid-term report after five years might meet the reporting requirement favoured by some delegations.

Mr SOLOMON (Office of the Legal Counsel) proposed that the words “every three years” should be replaced with the words “periodically, as appropriate,” to address reporting concerns.

Mr DARR (United States of America) supported the draft resolution as amended. However, he sought assurance that the amendments to subparagraph (OP3.4) concerning the allocation of funds would not be interpreted as authorization for the Director-General to prioritize and allocate funds to the traditional medicine strategy above areas of work outlined in any other resolution.

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.

The draft resolution, as amended, was approved.¹

¹ Transmitted to the Health Assembly in the Committee’s third report and adopted as resolution WHA67.18.

Follow-up of the report of the Consultative Expert Working Group on Research and Development: Financing and Coordination: Item 15.2 of the Agenda (Documents A67/27, A67/28 and A67/28 Add.1) (continued from the third meeting)

Ms PACHECO RODRIGUEZ (Plurinational State of Bolivia) requested that discussion of the item be postponed to allow further time for preparation of the draft decision proposed by the delegation of France.

The CHAIRMAN took it that the Committee wished to return to the item at a later stage.

It was so agreed.

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

Substandard/spurious/falsely-labelled/falsified/counterfeit medical products: Item 15.3 of the Agenda (Document A67/29)

Dr SHOHANI (Iraq) said that the topic under consideration was vital for medicines safety and the implementation of effective medicines policies in all countries. As part of its own medicines policy, Iraq monitored all medicine supply companies by requesting them to provide medicine registration certificates as proof of manufacturing standards and approval in the country of origin. Efforts were being made to raise public awareness of the issue of substandard/spurious/falsely-labelled/falsified/counterfeit (SSFFC) medical products, which were also being followed up at the institutional and grassroots levels, and to guarantee all available means of access to medical products through health institutions and as part of primary health care services. Any suspicious medical products were reported and all sources of supply were subject to ongoing periodic review. Information exchange with other countries was essential in order to ensure medicines safety, just as public-private partnerships were vitally important for tackling substandard medical products. Partnerships with civil society and international organizations, notably WHO, must also be strengthened in order to monitor the situation and ensure periodic reporting on non-compliant medical products and the companies involved.

Dr ORHII (Nigeria), speaking on behalf of the Member States of the African Region, said that, following the adoption of resolution WHA65.19 and the establishment of the Member State Mechanism on SSFFC medical products, the Region had taken a series of measures to integrate the Mechanism into African Member States' national systems, including by establishing a regional implementation committee to oversee execution of the work plan. A regional legal framework had been introduced to combat SSFFC medical products. A monitoring and surveillance system had been put in place in 33 Member States of the African Region, and two training workshops had been held, in which over 90 regulatory, pharmaceutical and laboratory experts had participated. More than 20 African Member States had reported incidents involving SSFFC medical products to date, some of which had involved medicines purporting to be WHO prequalified medicinal products. The International Criminal Police Organization (INTERPOL) had been tackling the matter in cooperation with national authorities.

The Member States of the African Region noted the serious threat posed by SSFFC medical products to sustainable and equitable growth and socioeconomic development and they remained committed to combating such products on the African market in coordination with the Member State Mechanism. He encouraged all countries to ensure that the Mechanism was based on effective coordination between Member States and regional groups in order to build strong oversight capabilities and safeguard the integrity of supply chains. He urged WHO to fund such activities adequately and called on private multinational pharmaceutical companies to join in efforts to tackle SSFFC medical products.

Dr KHAWAJA (Bahrain) said that the manufacture of SSFFC medical products was a serious crime that put lives at risk and undermined the credibility of health systems. A comprehensive control strategy must therefore be developed in partnership with the governmental, nongovernmental and professional sectors, with emphasis on raising health workers' awareness and building their capacity to detect and prevent the use of SSFFC medical products. Activities and behaviours that resulted in SSFFC medical products must be notifiable, particularly where they resulted in failed treatment or complications.

Action taken to stop the flow of such products into and out of Bahrain included the introduction of a robust quality control and surveillance system, import regulations and post-marketing follow-up measures. Laboratory testing also played an important part in the detection of SSFFC medical products. The health authorities systematically reported any side effects or other drug-related matters, worked closely with the customs authorities and exchanged information with Gulf States and the Regional Office for the Eastern Mediterranean. The Secretariat had a role to play in strengthening technical support to Member States for identifying legislative gaps and building regulatory capacities. It must also strengthen its global surveillance system for exchanging information on incidents involving substandard medical products.

Dr AMMAR (Lebanon) called on Member States to consider the Mechanism's governance proposals in a timely fashion and move forward with an effective and practical work plan. It was important for countries to maintain a general overview of the functioning of their health systems and to strengthen their regulatory capacities in order to safeguard the integrity of the supply chain and promote good distribution practices. Combating SSFFC medical products should be viewed not only as a technical exercise but also as a necessary step in building accessible health services and providing safe medical products at affordable prices. Controlling quality, pricing medical products, promoting generic medicines and transferring knowledge for local manufacturing should all be regarded as essential components in the fight against SSFFC medical products.

Ms SITI AIDA ABDULLAH (Malaysia) said that her country's efforts to tackle SSFFC medical products had been recognized by the Global Anti-Counterfeiting Group Network and it would be more than willing to share useful experiences with other Member States. The Government of Malaysia agreed with excluding considerations of trade and intellectual property rights from the scope of the Member State Mechanism and fully supported the initiative to identify the activities and behaviours that resulted in SSFFC medical products. She urged the Secretariat to conduct a global study into the behaviours of consumers, in order to reveal the demand for SSFFC medical products, and called on Member States to devise a realistic action plan for tackling the online marketing and sales of such products. Steps should be taken at global and national levels to raise the awareness of consumers, health care professionals and the pharmaceutical industry of the dangers and risks posed by SSFFC medical products, and to strengthen advocacy activities involving national judicial and political authorities. She strongly supported transparent information-sharing between Member State regulatory bodies concerning manufacturers and key players in the supply chain, as part of efforts to protect the integrity of the global pharmaceutical industry.

Dr PHAM THI CHINH (Viet Nam) said that her country was fully committed to achieving the stated objectives of the Member State Mechanism and the work plan and had strengthened its national regulatory system to facilitate medicine manufacture and pharmaceutical best practice. The Government of Viet Nam had also engaged in numerous global and regional cooperation activities to combat SSFFC medical products, including the initiative on building regional expertise in medicines regulation, information sharing, joint investigation and enforcement. She called on the Secretariat to support developing countries in purchasing testing equipment, as part of efforts to improve national detection capabilities, and stressed the need for the establishment of a mechanism to promote cooperation between neighbouring countries to prevent transnational trafficking of SSFFC medical products.

Ms ALVARADO SALAMANCA (Peru) welcomed the progress in combating SSFFC medical products described in the report (document A67/29) and expressed full support for the report's recommendations.

Dr HARTIGAN-GO (Philippines) agreed with the recommendations of the Open-ended Working Group to Identify the Actions, Activities and Behaviours that Result in Substandard/Spurious/Falsely-labelled/Falsified/Counterfeit Medical Products. He expressed full support for the work plan, particularly with regard to strengthening national regulatory capacities and increasing monitoring and coordination between Member States, and welcomed the proposed budget.

Dr KWANJAI AMNATSATSUE (Thailand) welcomed the proposals by Argentina and India on identifying activities and behaviours that fell outside the mandate of the Member State Mechanism and agreed with the Member State Mechanism to consider the issue from the perspective of public health rather than of trade and intellectual property. While supporting the measures contained in the report, she emphasized that Member States must safeguard the legitimacy of registered generic medicines when taking account of the non-exhaustive list of actions, activities and behaviours that resulted in SSFFC medical products. In view of the increasing international trade in pharmaceuticals, including the online marketing and sale of such products, Member States should establish effective and robust law enforcement and regulatory frameworks at national level and increase coordinated monitoring and surveillance efforts at national, regional and global levels. She supported the WHO global monitoring and surveillance project and called on all Member States to take an active part in it.

Dr BAŞÇI (Turkey) said that SSFFC medical products posed risks not only to individual health but also to public confidence in the health authorities and health systems. As it had become increasingly difficult to detect counterfeit medical products without the use of expensive laboratory tests, the Government of Turkey had decided to introduce a national "track and trace" system for pharmaceutical products and would welcome the opportunity to share with other Member States its experience of preventing the entry of counterfeit drugs into the legal supply chain. In countries with weak drug regulatory systems, problems would persist in accessing safe, efficacious and quality medicines; in that regard, the WHO global monitoring and surveillance system offered the ideal opportunity to strengthen national regulatory capacity and combat SSFFC medical products more effectively.

Dr MALECELA (United Republic of Tanzania) welcomed the proposal in the report to continue with annual rotation of the chairmanship of the Member State Mechanism but expressed concern that only 10% of the budget to fund the work plan in the biennium 2014–2015 had been secured: the Secretariat should take specific measures to bridge the funding gap. She acknowledged WHO's attempts to build national and regional regulatory capacity and noted that the United Republic of Tanzania had successfully held the African regional training session on the new WHO global monitoring and surveillance system in 2013.

Mr DENEKEW (Ethiopia) expressed support for global efforts to strengthen the detection and control of SSFFC medical products. His country remained committed to collaborating with other Member States on the non-exhaustive list of actions, activities and behaviours that resulted in such products. The Government of Ethiopia fully supported the work plan and would actively contribute to WHO initiatives aimed at guaranteeing access to safe, efficacious and quality medical products. WHO and other relevant partners should scale up the detection capacities of national regulatory authorities and facilitate cross-border collaboration to control SSFFC medical products.

Ms GARCÍA ARREOLA (Mexico) expressed full support for the work plan but noted that its success would be dependent on the provision of adequate funding. The Secretariat should bear such considerations in mind during the forthcoming financing dialogue.

Ms LEE Hyunhee (Republic of Korea) said that SSFFC medical products were a serious concern for global health and that the emergence of online marketing and sales of such products had increased the circulation of unsafe and counterfeit medicines. Member States should continue their discussions on how best to implement the work plan and effectively combat counterfeit medicines. It was important to establish robust governance objectives in order to promote cooperation in areas such as medical product pricing, monitoring and regulatory standards.

Dr BOND (United States of America) endorsed the progress made at the second meeting of the Member State Mechanism and congratulated Argentina on assuming the chairmanship. The Member State Mechanism must work towards achieving specific outcomes and the Steering Committee should therefore prioritize proposals for implementing the work plan. She commended the efforts of the Government of Argentina to promote international dialogue on track and trace measures for medical products and welcomed the forthcoming discussions on the matter.

Dr DAKULALA (Papua New Guinea) expressed concern at the funding gap in the work plan and called on the Secretariat to find a timely solution to the issue during the financing dialogue. He agreed that the chairmanship of the Member State Mechanism should rotate among the regions in alphabetical order on a yearly basis and acknowledged the work carried out by the Open-ended Working Group. His Government had taken several measures to combat SSFFC medical products but would require additional technical support in order to establish a drug quality control laboratory, a national drug regulatory authority and a drug registration system.

Mr AL KALBANI (Oman) expressed support for the work plan of the Member State Mechanism. Although positive steps had been taken to curb the problem of SSFFC medical products, more work was needed to strengthen the capacities of regulatory authorities and national and regional quality control laboratories and to promote cooperation, information exchange and studies on the subject. He proposed the elaboration of a protocol, along the lines of the Protocol to Eliminate Illicit Trade in Tobacco Products, aimed at reducing illicit trade in medicines.

Dr GÓLCHER-VALVERDE (Costa Rica) said that his country had established a national medical products commission, which collaborated at national and global level to implement practical preventive and detection measures against unsafe or counterfeit drugs. He expressed support for the work plan but noted that some of the objectives required strengthening; in view of the limited time available, he would submit proposed amendments to Appendix 1 and Appendix 2 to document A67/29 in writing. He called on Member States to improve their national drug regulatory systems in support of international efforts to build more effective global health systems.

Dr COITIÑO (Uruguay), speaking on behalf of the Group of the Americas, reaffirmed the Group's commitment to preventing and controlling SSFFC medical products and welcomed the advances made by the Member State Mechanism to safeguard the health of the global population. He

supported the decision to award the rotating chairmanship to Argentina and congratulated the outgoing Nigerian chairperson for his work at the helm of the Mechanism. He urged Member States to redouble their efforts to combat SSFFC medical products as part of a collaborative and coordinated international approach.

Mr PALOPOLI (Argentina) congratulated Brazil on its leadership during the technical discussions on the non-exhaustive list of actions, activities and behaviours that resulted in SSFFC medical products. His country was honoured to have guided the technical discussions on developing recommendations for health authorities to detect and deal with such actions, activities and behaviours and had subsequently drafted a reference document to assist in the development of a universal definition of SSFFC medical products. The reference document would soon be available online via the electronic platform and he urged Member States to use it as a starting point for an interactive global dialogue. He fully supported the Member State Mechanism's activities and called on the Secretariat to convene a meeting of the Steering Committee immediately after the Sixty-seventh World Health Assembly, so that all proposals for additional measures to the work plan could be analysed and prioritized in a timely fashion.

Ms VALLINI (Brazil) said that her country fully supported the proposal to develop recommendations for health authorities to detect and deal with actions, activities and behaviours that resulted in SSFFC medical products and was willing to provide financial support for a technical meeting for all Member States on the subject. She welcomed the WHO global monitoring and surveillance project and recommended that it should be directly managed and controlled by the Member State Mechanism. Noting the funding gap in the work plan for the biennium 2014–2015, she urged the Secretariat to take steps to tackle the issue during the forthcoming financing dialogue. She stressed the importance of combating SSFFC medical products from the perspective of public health rather than trade or intellectual property.

Dr TAKIAN (Islamic Republic of Iran) noted that the definition and interpretation of counterfeit medicines differed between countries and strongly urged Member States to agree on a global approach. The rational use of medicines on the basis of precise diagnosis, evidence-based clinical management, effective clinical guidelines and appropriate prescription of medicines could all greatly contribute to tackling counterfeit medicines. As to global monitoring and surveillance of SSFFC medical products, he urged Member States to collect accurate data through the use of effective technologies, such as electronic prescription systems, and to share the data obtained with relevant stakeholders.

Mr KOTALWAR (India) recalled that his country had participated actively in the second meeting of the Member State Mechanism and would submit a proposal regarding element 5(b) of the work plan on identifying activities and behaviours that fell outside of the mandate of the Mechanism. He therefore welcomed the Argentina's proposal to establish an electronic platform for such work and supported its chairmanship of the Member State Mechanism. The Government of India remained committed to strengthening and building the capacity of its national drug regulatory authority and welcomed WHO's ongoing technical support for those efforts.

Mr ARUSTIYONO (Indonesia) fully endorsed the outcomes of the second meeting of the Member State Mechanism. The Government of Indonesia had established a national drug regulatory authority tasked with combating SSFFC medical products and had strengthened national, regional and global collaboration and cooperation on regulatory matters. He stressed the importance of fully implementing the work plan and called on Member States to address the funding gaps in the SSFFC medical products programme.

Mr GAO Tianbing (China) said that SSFFC medical products posed a serious threat to human health. He underscored the requirement for national drug regulatory authorities to share information and knowledge, in order to strengthen national, regional and global detection, prevention and control capacities. He urged the Secretariat to safeguard the financial sustainability of the work plan as part of efforts to ensure access to safe, efficacious and quality medical products.

Dr A. PILLAY (South Africa) welcomed Member States' agreement on the importance of devising a universal definition of SSFFC medical products and recommended that the role and functions of other United Nations stakeholders in joint efforts should be enhanced and extended in order to better guarantee the safety, efficacy and quality of medical products. He urged the Steering Committee of the Member State Mechanism to prioritize the work plan so that Member States could begin to formulate their own national plans.

Mrs NAARENDORP (Suriname) thanked Nigeria for its excellent leadership of the Member State Mechanism and congratulated Argentina on assuming the chairmanship. Her country remained committed to improving its national drug regulatory capacity and reiterated the importance of considering SSFFC medical products from the perspective of public health rather than trade or intellectual property.

Dr ELOAKLEY (Libya) requested clarification regarding the process for appointing a new chairperson of the Steering Committee after Nigeria stepped down.

Ms Li-Ying LAI (Chinese Taipei) said that Chinese Taipei remained committed to combating SSFFC medical products and had taken a series of measures to prevent, detect and control such products, including the introduction of pharmaceutical regulations, the establishment of an anti-counterfeiting taskforce and the introduction of public campaigns to raise awareness of the need for medicines safety.

Ms KUSYNOVÁ (International Pharmaceutical Federation), speaking at the invitation of the CHAIRMAN, welcomed the report. However, in Appendix 1, she noted that “dispensing” had been omitted from the list of actions associated with SSFFC medical products, all of which were encouraged by inadequate supervision by the relevant authorities. Limited access to medicines could jeopardize the integrity of the supply chain, and shortages of medicines created gaps that raised the risk of SSFFC medical products infiltrating supplies. Such shortages affected both developed and developing countries, as had been highlighted at the International Summit on Medicine Shortages, held in Toronto, Canada in June 2013. It was encouraging that the Member State Mechanism had managed to validate its work plan, but the financing of the work plan and the fact that the Mechanism only met once a year were outstanding areas of concern. At its second meeting, the Mechanism had permitted remote observation of the meeting of the Steering Committee and she requested that the approach should be extended to nongovernmental organizations in official relations with WHO. She reaffirmed her interest in contributing to the work plan.

Ms SESTER (International Pharmaceutical Students' Federation), speaking at the invitation of the CHAIRMAN, supported the work of the Member State Mechanism in the fight against fake medicines, which constituted a public health threat and put patients and the general public at risk. A comprehensive strategy to combat the manufacture and distribution of fake medicines required the active participation of all stakeholders and should leverage several competencies at both local and global level. Counterfeiting medicine and vaccines was a crime against patients, and producers of fake medicines were criminals. Tackling fake medicines required strong policies, legislation and penalties for those producing fake products. Robust coordination among international organizations was vital in ensuring that the problem was tackled. As the leader in global health, WHO had an unparalleled role

to play. She stood ready to provide support for increasing awareness and understanding of the crime, in order to protect patients from fake medicines worldwide.

Mr DE JONCHEERE (Essential Medicines and Health Products) thanked delegates for their comments. Clearly, SSFFC medical products had a detrimental effect on people's health and also undermined the credibility of health services. Attention had also been directed towards the growing complexity of the supply chain, including Internet sales, and the threat that posed to the quality of products on the market. Many delegates had indicated how they were responding at national level, including through multisectoral action and bilateral efforts with neighbouring countries. More than 80 Member States were now participating in the monitoring project to construct a validated body of evidence based on notified cases. The project was also helping countries to investigate national cases in order to identify an effective response and prevent similar recurrences.

At the second meeting of the Member State Mechanism, in November 2013, governance issues had been agreed and the work plan approved, including activities directed at strengthening regulatory authorities, raising awareness, securing the supply chain, sharing information, making use of new technologies and carrying out surveillance. Two working groups were being set up under the leadership of Argentina and India, and two online platforms would further the discussion, which would be resumed at the third meeting of the Mechanism. Referring to the concerns expressed by several delegates at the insufficiency of the budget available for the work plan, he said that discussions would be held with countries on the Steering Committee on how to bridge that gap.

He expressed appreciation to Nigeria for its skilled leadership of the Steering Committee and welcomed Argentina as the incoming chairperson. Regarding the chairmanship of the Steering Committee, the Member State Mechanism had agreed that the chairmanship should rotate among the regions and that the next chairperson would be from the Region of the Americas. Following discussion on the matter and a proposal by Uruguay, Argentina had been elected to take up the post of chairperson after the conclusion of the Sixty-seventh World Health Assembly.

The Committee noted the report.

Dr Akauola took the Chair.

Access to essential medicines: Item 15.4 of the Agenda (documents A67/30 and EB134/2014/REC/1, resolution EB134.R16)

Dr KHAWAJA (Bahrain), welcoming the report by the Secretariat, said that medical insurance was available to all Bahraini citizens and that it covered essential medicines, including those against noncommunicable diseases and HIV/AIDS and in connection with reproductive health. People without Bahraini citizenship also had access to essential medicines: further measures would be introduced to strengthen the social security system and ensure that essential medicines were available to them at a reasonable cost. Turning to the private sector, she said that the Government had taken a decision to reduce the price of essential medicines by 50% for both Bahraini citizens and non-nationals.

Mr LI Bo (China) outlined China's particular concerns in connection with access to essential medicines: strengthening research and development exchanges in the areas of production and use; supporting developing countries in formulating effective national policies on essential medicines and drawing up national lists of essential medicines, with emphasis on children's medicines; and strengthening education and training for health care professionals, as well as the public. In order to extend the availability of essential medicines, the Secretariat should strengthen its exchanges and cooperation with Member States to shape national medicines policies that covered research and development, financing, selection, procurement, distribution, use, regulation, pricing and reimbursement, with emphasis on the promotion of essential medicines. She called on Member States to adopt the draft resolution recommended by the Executive Board in resolution EB134.R16.

Ms VACA (Colombia) commended the progress made on improving access to essential medicines. Nonetheless, faced with the high cost of new vaccines and medicines to treat cancer and noncommunicable diseases, as well as a range of other issues, countries recognized the need for a new model for health-related research and development that would de-link the cost of research and development from the end price of medical products, allowing them to be aligned with health priorities. She acknowledged the Secretariat's efforts to make progress in implementing the provisions set out in resolution WHA66.22 and decision WHA66(12) and supported the draft resolution. However, it could be amended in a way that clarified the indicators to be used in evaluating projects and aligned them with the criteria set out in the report of the Consultative Expert Working Group on Research and Development: Financing and Coordination. The indicators could be strengthened and defined using regional mechanisms; several regions, including the Region of the Americas, had already made advances in that field. The number of Member States participating in the Good Governance for Medicines programme should be increased. Given the importance for health of the subject matter, she advocated continuing the discussions without a break, in order to be able to report on the outcome of the work before 2016.

Ms CHOZOM (Bhutan), speaking on behalf of the Member States of the South-East Asia Region, welcomed the draft resolution on access to essential medicines. Although most Member States of the Region had national drug policies, they were not always adequately implemented. Between 2010 and 2013, a situation analysis of pharmaceuticals in health care delivery had been carried out in all Member States of the Region, which had highlighted numerous shortcomings, including inadequate monitoring of medicines consumption, irrational use of medicines and interruption of medicines supplies.

She called on the Secretariat to support the exchange of information and collaboration among Member States in order to identify best practice in drawing up and implementing medicines policies, including the use of inventory management systems and reference prices for medicines. The Secretariat might consider providing support to Member States with limited production and procurement capability. She also drew attention to the importance of research in relation to procurement, supply and rational use of essential medicines. While she broadly supported the draft resolution, the following amendments might serve to strengthen the text: in subparagraph 1(1), the deletion of "recognize the need and" at the beginning of the first line; the insertion of the words "and implementation" between "development" and "of"; the replacement of the words "strengthened pharmaceutical" with "to strengthen good governance of pharmaceutical systems including"; and the replacement of the word "coordinated" with "to coordinate". In subparagraph 1(9), she proposed the insertion of the words "using effective inventory management systems" after "availability".

Mr TALUKDER (Bangladesh) said that his Government gave priority to improving access to essential medicines and maintaining a national essential medicines list based on evidence-based selection of a limited range of medicines, efficient procurement, affordable prices, effective distribution systems and rational use. In 2008, the list had been revised and expanded with support from WHO. However, a lack of suitably trained staff and a weak infrastructure made it difficult to monitor the availability of quality medicines. Adequate resources were therefore needed in order to modernize and effectively implement the national drug policy. Local pharmaceutical manufacturers required proper support to be able to carry out the research needed to produce essential medicines. There was also a lack of awareness in relation to regulatory mechanisms, pricing, rational use of medicines and monitoring.

Dr SHOHANI (Iraq) emphasized the importance of a clear policy for actively managing medicines. Iraq had a national committee that selected medicines, including essential medicines, on the basis of scientific evidence. Efforts were also made to educate people regarding the use of medicines in order to prevent antimicrobial resistance, as well as avoid harmful side effects.

Mr COTTERELL (Australia) commended the report, thanked the delegation of China for its leadership in preparing the draft resolution and recommended its adoption. On a point of order, he asked the Secretariat to read out any proposed amendments to the draft resolution at the end of the discussion to enable the Committee to consider them. He reminded Member States that the draft resolution had already been extensively discussed.

Ms SITI AIDA ABDULLAH (Malaysia) fully supported the draft resolution and endorsed the recommendations contained therein. In addition, she encouraged Member States to adopt and apply the WHO Good Governance for Medicines programme in all critical processes in the complex medicine chain. Recognizing the impact of intellectual property rules on innovation and access to medicines, she supported the use of flexibilities in the Agreement on Trade-Related Aspects of Intellectual Property Rights in order to increase access to affordable medicines and safeguard public health. She called on the Secretariat to provide technical support to Member States, under the mandate conferred by WHO's global strategy and plan of action on public health, innovation and intellectual property, to make effective use of those flexibilities to facilitate the acquisition of affordable medicines, particularly for HIV/AIDS treatment. Member States should also share best practices related to the assessment of health technologies in order to encourage evidence-based selection of essential medicines and new high-priced innovative medicines, especially for the treatment of cancer and rare diseases.

Dr JASUNDARA BANDARA (Sri Lanka) said that, in order for countries to make progress towards universal health coverage and achieving the health related Millennium Development Goals, access to essential medicines was assuming increasing importance. He strongly supported the emphasis placed on the evidence-based selection of a limited range of medicines and advocated the strengthening of technology transfer for generic medicines, as well as a sharper focus on South-South cooperation. Countries with small populations found it difficult to broaden access to essential medicines. He reiterated the need for the Secretariat to formulate a mechanism to provide guidance to such countries on reference prices for pharmaceutical products, as well as information on certified, quality-assured potential suppliers of small quantities of highly priced essential medicines in order to facilitate procurement at a competitive price.

Dr GYANSA-LUTTERODT (Ghana) said that although essential medicines were a major driver of universal health coverage, geographical and financial barriers often made access to them impossible. Local production therefore presented a means of overcoming those barriers. The African Union Pharmaceutical Manufacturing Plan and the Economic Community of West African States' local manufacturing plan represented two strategic documents for improving access to medicines in the Region. Local production would allow national regulatory authorities to exercise their powers in the case of product recall and other regulatory measures. Social health insurance was another means of improving access to medicines. However, it involved setting priorities, especially in evidence-based clinical evaluation, where economic considerations played an important part in the rational selection of medicines, as well as in defining benefits packages. She commended the report and urged Member States to adopt the draft resolution.

Dr DAKULALA (Papua New Guinea) thanked the Secretariat for carrying out regional actions to improve access to, and the availability, affordability and rational use of, safe, effective and quality-assured essential medicines, including development of the regional framework for action on access to essential medicines (2011–2016) in the Western Pacific Region. Papua New Guinea had a national list of essential medicines; tools had been developed that would ensure an adequate supply of them, and he thanked those partners and donors who had supported national efforts in that regard. He endorsed the report and the draft resolution.

Dr HARTIGAN-GO (Philippines), welcoming the draft resolution, said that his country was committed to ensuring access to essential medicines, particularly those against vaccine-preventable diseases, tuberculosis, malaria and HIV/AIDS. An increase in health financing had expanded access to essential medicines to treat noncommunicable diseases. His Government had addressed market failures and had implemented international rules on intellectual property rights as well as the flexibilities contained in the Agreement on Trade-Related Aspects of Intellectual Property Rights. In line with WHO's Good Governance for Medicines programme, his country was implementing the electronic drug price monitoring system. It had also further strengthened its policies on rational use of medicines and employed a more rigorous evidence-based process for selection of medicines. He welcomed technical support from the Secretariat and its increased collaboration with Member States to ensure access to essential and affordable medicines.

Mr DENEKEW (Ethiopia) endorsed all strategies designed to prevent and control noncommunicable diseases, including packages of essential technologies and the strengthening of regulatory systems. He also supported stronger innovative research systems and capacity-building to encourage local production of medicines. His country would continue to work closely with WHO and other partners in order to implement the recommended strategies.

Mr HARPUR (United Kingdom of Great Britain and Northern Ireland) asked for the United Kingdom to be added to the list of sponsors of the draft resolution.

Dr BAŞÇI (Turkey) emphasized the importance of access to medicines and said that Turkey monitored medicines supply and distribution processes closely. He described the national track and trace system for monitoring the supply chain from manufacturer to consumer. An early warning system and a strategy for tackling shortages were being developed. Progress had been made towards universal health coverage and more than 95% of drug treatments were covered by the national health insurance scheme. The national essential medicines list had recently been updated in line with WHO's 18th Model List of Essential Medicines. Countries tended to experience common problems with regard to essential medicines, all of which could be more easily solved through cooperation, implementing an overall strategy under the guidance of WHO.

Dr PHAM THI CHINH (Viet Nam) endorsed the report and the draft resolution. Her Government had already implemented many of the recommendations contained in the draft resolution, had published its sixth list of essential medicines, which included paediatric formulations, and was committed to giving effect to the remaining recommendations. In that regard, she proposed that subparagraph 1(7) of the draft resolution should be amended to include the words "as appropriate and through transparent mechanisms and structures," between "involvement" and "in enhancing". In terms of barriers to access to essential medicines referred to in subparagraph 1(8), inequitable access to essential medicines remained a serious concern for disadvantaged and vulnerable populations, and the complex interplay of ethnicity and social and cultural barriers to access were poorly understood. She requested the Secretariat to work with Member States to design innovative tools and strategies to overcome such barriers.

Dr A. PILLAY (South Africa), speaking on behalf of the Member States of the African Region, commended the report and WHO's strategy on medicines as reflected in the Twelfth General Programme of Work, 2014–2019. Progress towards achieving the Millennium Development Goals would not be made so long as barriers preventing access to medicines remained. Although countries had made notable advances towards achieving the Goals, particularly with respect to accessing medicines to fight HIV, malaria and tuberculosis, access to other medicines, such as vaccines and anti-cancer medicines, was still denied to millions of people in both developed and developing countries.

The high price of medicines, particularly in the private sector, was a key barrier to access to affordable essential medicines in developing countries. Adequate, sustainable and equitable financing

of medicines was required. The WHO Expert Committee on the Selection and Use of Essential Medicines might consider producing a list of medicines that were essential for public health but that were currently unaffordable.

The low public sector availability of medicines in many developing countries was another barrier to access. Increasing the use of quality-assured generic medicines was a key strategy for improving the affordability of medicines. A range of policy options was available to promote the use of generics. Patents also had a dramatic impact on access to medicines when they were used to prevent competition. Several factors therefore affected access to medicines: the existence of a price regulatory system; utilization of flexibilities in the Agreement on Trade-Related Aspects of Intellectual Property Rights; a system for tracking the availability of medicines through the medicine supply chain; a simplified, harmonized, efficient and transparent regulatory approval process, particularly for generic medicines; and an effectively implemented generic substitution policy. All such interventions should be applied through an integrated system. He supported the draft resolution.

Mr KOLKER (United States of America) commended the report and supported the draft resolution. Access to essential medicines was essential for achieving universal health coverage and better health outcomes. The vast majority of medicines on the WHO Model List of Essential Medicines were not under patent protection, therefore Member States should examine local barriers to access and enhance their systems in order to increase uptake. Further, the Secretariat should support countries in building their systems and capacity to improve access to, and rational use of, essential medicines. He agreed with the delegate of Australia that last-minute amendments threatened to delay approval of a draft resolution that had already been widely discussed and on which consensus had been reached.

Mr TYSSE (Norway) said that he regarded access to essential medicines as a priority area for accelerating progress towards the health-related Millennium Development Goals and beyond. Although significant progress had been made in improving access to essential medicines, market failures caused by low, unpredictable or fragmented demand for products represented a major challenge. Norway was therefore working with various United Nations initiatives to shape markets and increase access to essential medicines. He advocated making use of the full range of tools available, such as volume guarantees in the case of low demand, support for regulatory processes in the case of slow qualification and approval of new products, and initiatives such as the Medicines Patent Pool, for exploiting patent system flexibilities. It was important to implement and interpret the Agreement on Trade-Related Aspects of Intellectual Property Rights in a way that supported public health by promoting access to existing medicines and the development of new ones. He supported the draft resolution.

Dr NDIAYE (Senegal) strongly supported the draft resolution and called for particular attention to be paid to strengthening systems for the supply and distribution of essential medicines in developing countries. In placing emphasis on procurement, the Government of Senegal had further committed itself to achieving universal health coverage following an initiative, in September 2013, to offer free care for children under five years of age; sufficient quantities of high-quality, low-cost essential medicines were now available to the whole population. Centralized procurement of essential medicines was a key factor in attaining universal health coverage. Procurement centres should not just be logistical platforms; they should also have the capacity to fulfil a public health role. Support should therefore be given to strengthen public procurement of essential medicines, in particular by building countries' capacity to evaluate manufacturing plants and prices; establishing databases on medicine suppliers; introducing quality assurance systems; promoting exchanges of information on medical products for priority programmes in the case of emergencies or shortages; and aligning partners in national supply and distribution systems.

Ms GARCÍA ARREOLA (Mexico) said that in its efforts to ensure that the population had access to essential medicines, Mexico was making full use of flexibilities in the Agreement on Trade-Related Aspects of Intellectual Property Rights. The Government had begun to implement some of the recommendations contained in both the draft resolution and the report on access to essential medicines. A national list of essential medicines had been in existence for nearly 40 years. Mexico also participated in the Good Governance for Medicines programme, which involved being evaluated against a set of international standards in order to identify weaknesses and thereby improve access to essential medicines.

Mr BAYU TEJA MULIAWAN (Indonesia) said that his country's national medicines policy encompassed accessibility, regulation and rational use. The regulation component focused on quality assurance, safety and efficacy. A national health insurance programme had been introduced in January 2014, and a national formulary covering essential medicines served as a reference for health care facilities. In order to improve transparency and accountability and to ensure an effective and efficient process, an electronic procurement system had been developed in 2013. Continuing education and training programmes promoted the rational use of medicines, as well as appropriate use of antibiotics and prescription medicines. Monitoring and evaluation had been undertaken to identify barriers to equitable availability, affordability and use of medicines. His Government was considering adapting national legislation in order to capitalize on flexibilities in the Agreement on Trade-Related Aspects of Intellectual Property Rights. He supported the draft resolution and requested the Secretariat to provide technical support to allow its full implementation.

Ms VALLINI (Brazil) reiterated that an effective essential medicines policy played a crucial role in attaining equity and sustainability, achieving the health-related Millennium Development Goals and improving the quality of the treatment and care of noncommunicable diseases. The success of such a policy depended on numerous factors, including efficient procurement, affordable prices, efficient distribution systems and rational use of medicines. Countries should not regard intellectual property patents as a barrier to access to essential medicines, but should exploit their potential in order to develop national capacities. She supported the draft resolution in its present form, as it would strengthen countries' efforts to improve both the management and availability of essential medicines and, ultimately, people's health.

Mr KIM Young-hak (Republic of Korea) said that as his country had cosponsored the draft resolution, he strongly advocated its approval by the Committee. His Government had established a national health insurance scheme covering the whole population, under which medicines were provided on the basis of their cost-effectiveness and clinical utility. The intention was to further extend the existing integrated information technology system covering monitoring of the supply and distribution of medicines. There was also a need to minimize the duplication of prescriptions, as well as the side effects of medicines.

Dr NITHIMA SUMPRADIT (Thailand) said that achieving good governance in pharmaceutical systems and providing medicines at affordable prices were major challenges for developing countries. Thailand was making progress in the area of affordability through measures including price negotiation, bulk purchasing, centralized procurement and full use of flexibilities in the Agreement on Trade-Related Aspects of Intellectual Property Rights. Shortages of essential medicines were prevalent in developing countries and required a range of strategies to overcome them, such as regular communication and information-sharing among manufacturers, health insurance purchasers, regulatory authorities and health care providers.

Mr PUSP (India) commended the report on access to essential medicines and expressed broad support for the draft resolution. However, more attention should be paid to certain areas, such as the need to support technology transfer and to make greater investments in post-marketing surveillance of

medicines and vaccines. Access to essential medicines should also cover certain critical medicines, such as anti-cancer medicines, irrespective of cost. He therefore asked for the words “including critical medicines” to be inserted after “essential medicines” in the first line of subparagraph 1(2) of the draft resolution. It was a cause for concern that the draft resolution failed to mention the allocation of resources for activities related to access to essential medicines. The promotion of local and regional production of essential medicines was also important. Where economies of scale could be realized, local production could contribute towards lowering the price of medicines. Member States should therefore receive guidance on promoting local production.

It was also time to consider reviewing the selection criteria for the WHO Model List of Essential Medicines and including new medicines with proven therapeutic advantages. Full utilization of the flexibilities in the Agreement on Trade-Related Aspects of Intellectual Property Rights had been under attack, and he urged WHO to counter such attacks in order to improve access to essential and critical medicines in the interests of public health.

Dr MUTAMBU (Zimbabwe) reiterated the importance of countries making full use of the flexibilities in the Agreement on Trade-Related Aspects of Intellectual Property Rights in order to ensure access to essential medicines. Funding of the WHO programme on the rational use of medicines was inadequate and she therefore recommended that the necessary resources should be made available from the regular programme budget.

Dr QADIR (Afghanistan) commended the report, which provided a clear strategy for improving access to essential medicines. Afghanistan had its own essential medicines policy and essential medicines list, but neither had been fully implemented owing to a lack of technical capacity and financial resources. A national drugs policy alone would not improve access to quality essential medicines without legislation that was enforced and sufficient technical and financial resources to support the establishment of an effective drug management system, covering stock control and delivery. He broadly supported the draft resolution, provided that it could be adapted to match the contexts of individual countries and that sufficient resources were allocated to ensure its global implementation.

Mrs NAARENDORP (Suriname), speaking on behalf of the Member States of the Union of South American Nations, thanked the Secretariat for the actions taken to strengthen Member States’ access to essential medicines, although large population groups, both regionally and globally, continued to face barriers to access. The necessary measures to promote access to affordable, quality, safe and efficacious medicines were multiple and responded to different situations. Effective implementation of the policy required a multisectoral approach, as well as underlying coordination of the health sector, in order to ensure that the right professionals were trained, research undertaken and medicines that patients needed, rather than those that generated profits, were produced and distributed. The current model of incentivizing research and development, based on obtaining monopolies through pharmaceutical patents, had failed to meet the needs of developing countries. Pressure to incorporate in collective financing arrangements expensive technologies that were not as cost-effective as earlier models threatened the financial sustainability of health systems. The high cost of new technologies also placed a burden on household economies, leading to poverty. Urgent action needed to be taken by the international community, including stakeholders in health systems.

Reaffirming the Alma-Ata Declaration of 1978, according to which the provision of essential medicines was one of the pillars of primary health care, she recommended that full use should be made of the provisions in the Agreement on Trade-Related Aspects of Intellectual Property Rights, in particular the flexibilities recognized by the Doha Ministerial Declaration on the TRIPS Agreement and Public Health. Also reaffirming the recommendations in the report of the Consultative Expert Working Group on Research and Development: Financing and Coordination, she called for greater efforts to be made to implement the global strategy and plan of action on public health, innovation and intellectual property. Countries also needed strong regulatory systems geared to improving access to

safe, quality and affordable medicines. Approaching health from a social determinants perspective and implementing integrated multisectoral policies were also key components in ensuring that people had access to essential medicines.

Mr SILLO (United Republic of Tanzania), recalling numerous WHO initiatives that his country had acted on and recently updated, said that an electronic logistics management information system had recently been installed in order to strengthen the supply chain. The United Republic of Tanzania was moving towards universal health coverage with the prospect of a mandatory health insurance scheme for all citizens. Recognizing that sustainable access to essential medicines depended on the capacity of Member States to produce them locally, his country had implemented a strategy to support its own domestic production. He acknowledged the continued support of the Secretariat to Member States, particularly in the African Region, for building capacity through technology transfer and the Prequalification of Medicines Programme; however, specific support to facilitate local production of essential medicines would be particularly welcome. He supported adoption of the draft resolution.

Dr MACKIE (New Zealand) welcomed the report and its recommendations, as well as the leadership role played by China. The proposed strategy targeted the barriers that continued to prevent medicines reaching those most in need. He had noted the proposed interventions to enhance the rational use of medicines, in particular those aimed at limiting the emergence and spread of antimicrobial resistance.

The meeting rose at 12:25.

FIFTH MEETING

Friday, 23 May 2014, at 14:35

Chairman: Dr S. AKAUOLA (Tonga)

later: Dr M. ASADI-LARI (Islamic Republic of Iran)

later: Dr S. AKAUOLA (Tonga)

HEALTH SYSTEMS: Item 15 of the Agenda (continued)

Access to essential medicines: Item 15.4 of the Agenda (Documents A67/30 and EB134/2014/REC/1, resolution EB134.R16) (continued)

Dr GÓLCHER-VALVERDE (Costa Rica) said that his country had been participating, with other Central American countries and the Dominican Republic, in joint price negotiations for medicines, including essential medicines for noncommunicable diseases. However, his country's achievements in ensuring access to medicines continued to be threatened by high medicine prices. Pharmaceutical companies preferred to concentrate on the profitable market niche of unresolved diseases and promoted expensive personalized treatments for diseases such as cancer, leaving health systems with a stark choice between denying patients the best treatments available and potentially bankrupting the national health system within a few years. His Government believed that the price of expensive medicines should be related to the wealth of each country. WHO's recommendations should take into account both the genuine therapeutic value of a product and its cost-effectiveness. Those medicines and procedures that constituted real therapeutic innovations should be acknowledged as such by WHO, which should also set the reference price.

Ms HALÉN (Sweden) said that Sweden wished to be added to the list of sponsors of the draft resolution contained in resolution EB134.R16.

Mr PIPPO (Argentina) emphasized the importance of regional purchasing mechanisms such as PAHO's Regional Revolving Fund for Strategic Public Health Supplies, which had significantly reduced the cost of procuring vaccines by setting a single regional price for middle- and low-income countries. That initiative had facilitated access to vaccines, saved millions of lives and reduced health inequalities in a region often presented as the most unequal in the world.

Dr ALABOUD (Syrian Arab Republic) said that, because some of its production facilities had been subject to terrorist attack, his country had had more difficulty in producing sufficient essential medicines in recent years, while sanctions meant that there were some essential medicines to which the country no longer had access. He proposed adding a paragraph to the draft resolution stipulating that medicines, especially essential medicines, should be exempt from sanctions, so that countries could continue to produce medicines as needed.

Mr CORRALES HIDALGO (Panama) said that any global strategy to tackle the high cost of medicines must also decide how to break down multisectoral commercial and structural barriers. He expressed his appreciation to China for its leadership in the area of essential medicines.

Mr SEGARD (Canada) supported the draft resolution, as amended. He encouraged Member States and the Secretariat to pay particular attention to paediatric formulations and dosages when drawing up lists of essential medicines and developing and implementing essential medicines programmes.

Mr AL KALBANI (Oman) said that, in order for countries to take advantage of the flexibilities recognized by the Doha Ministerial Declaration on the TRIPS Agreement and Public Health, many administrative and legal measures had to be taken which might constitute a burden for some countries. He therefore proposed that a new subparagraph should be added to the draft resolution after the current subparagraph 2(8), requesting the Director-General, in cooperation with relevant international bodies, to review procedures in those countries that would like to make use of flexibilities in the Agreement on Trade-Related Aspects of Intellectual Property Rights, in order to make such procedures less onerous.

Ms PACHECO RODRIGUEZ (Plurinational State of Bolivia) said that her country's national health development plan for 2010–2020 had three major strategic linchpins: universal access to a single health system, health promotion and health governance. Access to essential medicines was still a problem for a number of developing countries, in terms of both supply and cost. Countries should take advantage of the flexibilities recognized by the Doha Ministerial Declaration and beware of the attempts to reduce or limit use of those flexibilities made by certain countries in their bilateral and regional agreements.

Dr FONES (Chile) said that WHO's strategy for improving access to essential medicines promoted more efficient management of medicines, more rational use of resources and higher-quality health care. Good governance of pharmaceutical practices was one way of improving procurement and supply, and included tools for assessing the transparency and vulnerability of specific areas of the State pharmaceutical sector.

Ms BARCLAY (International Planned Parenthood Federation), speaking at the invitation of the CHAIRMAN, said that essential medicines in the area of reproductive health were sometimes neglected in the national procurement process. Preventive medicines in general were often considered to be of lower priority than curative products. In order for the WHO Model List of Essential Medicines to be implemented globally, the current target under Millennium Development Goal 8 concerning access to affordable essential medicines in developing countries should be rolled over into the post-2015 framework. As maternal health was often used as a proxy measure for a functioning health system, a range of reproductive, maternal and child health products should be used as tracer products under that target.

Ms KUSYNOVÁ (International Pharmaceutical Federation), speaking at the invitation of the CHAIRMAN, said that increasing access to medicines must be systematically accompanied by access to pharmaceutical expertise to ensure their responsible use. In order to improve access to reliable medicines, especially in developing countries, her organization was developing, in an evidence-based project supported by WHO, biowaiver monographs that reduced the requirements for assessment of the bioequivalence of generic medicine products in clinical trials by means of dissolution tests, without compromising safety. That eased the approval process, thus making more generics available. Forty monographs had so far been published. The candidate medicines for future biowaiver monographs came primarily from the WHO Model List of Essential Medicines.

Ms LEEV (Global Health Council, Inc.), speaking at the invitation of the CHAIRMAN and also on behalf of the Drugs for Neglected Diseases initiative and the Medicines Patent Pool Foundation, said that, although 64% of adults who needed essential HIV treatment had access to it, the same was true of only 34% of children, even though 80% of children born with HIV who did not receive

treatment would die before their third birthday. The treatment of children with HIV was hampered by the fears of health workers, arising from a lack of knowledge, and by the lack of treatment options. For example, only 12 of the 27 antiretroviral drugs approved for use in adults had also been approved for use in children under two years old.

Ms SOULARY (OXFAM), speaking at the invitation of the CHAIRMAN, said that WHO's prequalification programme should be expanded to include other medicines, especially antibiotics and medicines for communicable and noncommunicable diseases. That expansion would require policy, advocacy and normative work. High prices and the lack of price transparency continued to be a barrier to access to medicines in developing countries. Competition from generic medicines was a very effective mechanism for achieving sustained low prices. Pharmaceutical companies must recognize that the world could not continue to pay such high prices for new medicines, and countries needed to be supported in using the flexibilities recognized by the Doha Ministerial Declaration. She called on Member States to ensure that WHO had the resources to fulfil its core functions related to medicines, and on the Secretariat to scale up its leadership in addressing new incentives for research and development and supporting countries in implementing the flexibilities.

Mr JASOVSKY (International Pharmaceutical Students' Federation), speaking at the invitation of the CHAIRMAN, expressed concern at the inequity in access to essential medicines owing to the economic nature of the private sector, which did not reflect societal needs. Innovation should be driven by new business models that broke the link between research and development costs and the price of medicines. Opportunities for open research initiatives and public-private partnerships required more investigation. Quality and safety requirements for medicines should be harmonized in order to support continuity in the manufacture and supply of essential medicines.

Ms BARRIA (Medicus Mundi International – International Organisation for Cooperation in Health Care), speaking at the invitation of the CHAIRMAN, welcomed the renewed focus on access to medicines. The resources currently pledged for such programmes were negligible compared with the pharmaceutical industry's spending on marketing. Her organization urged Member States to address two issues. The first was the criterion of "comparative cost-effectiveness" used for setting national priorities on essential medicines, which excluded almost all new patent-protected drugs. Cost-effectiveness considerations needed to be seen in the context of the possible use of flexibilities in the Agreement on Trade-Related Aspects of Intellectual Property Rights in order to reduce costs. Secondly, the draft resolution did not adequately address technology transfer and local manufacturing capacity – an area where cooperation should be strengthened, especially between low- and middle-income countries. Meanwhile, WHO continued to face the challenge of managing conflicts of interest arising out of its dealings with the pharmaceutical industry.

Ms AAGAARD (MSF International), speaking at the invitation of the CHAIRMAN, said that high medicine prices posed a particularly acute problem for people living in so-called "middle-income" countries, which were home to three quarters of the world's poor. Those countries needed to implement measures to promote affordability, with WHO's support, by reforming patent law and making robust use of flexibilities in the Agreement on Trade-Related Aspects of Intellectual Property Rights. Her organization welcomed the draft resolution but believed that it should call for the scope of WHO's prequalification programme to be expanded beyond HIV/AIDS, tuberculosis and malaria. Secondly, it should strengthen WHO's mandate to promote a reform of the current research and development system, which relied too heavily on patents and intellectual property. Thirdly, WHO should remain focused on the interventions best suited to arriving at sustainable and Member State-driven strategies to ensure affordable access. WHO should not passively endorse new initiatives such as tiered pricing and market segmentation, which left millions of patients unserved.

Dr REED (Stichting Health Action International), speaking at the invitation of the CHAIRMAN, said that it was not clear where the funding would be obtained to implement the draft resolution, or many other related activities. Sufficient funds must be made available.

Ms BENTALEB (International Federation of Medical Students' Associations), speaking at the invitation of the CHAIRMAN, said that free trade agreements such as the Trans-Pacific Partnership and the Transatlantic Trade and Investment Partnership were now threatening to limit access to essential medicines. Some emerging economies were demanding more stringent patents, even in the face of pressure from governments of high-income countries and the pharmaceutical industry. Trade agreements that imposed the high-income world's loose patent standards on low- and middle-income countries would undermine efforts to accord higher priority to rational medical and legal standards than to profits.

Dr KIENY (Assistant Director-General) said that the Secretariat was committed to supporting Member States in sharing best practices in the area of medicines policies, procurement, supply, rational use, pricing and good governance, as requested by the delegates of Member States who had taken the floor during the discussion. As part of the implementation of the global strategy and plan of action on public health, innovation and intellectual property, WHO would support countries that chose to invest in local production of health technologies.

The CHAIRMAN suggested that, owing to the large number of proposed amendments, the Secretariat should prepare an amended version of the draft resolution for circulation at a later date.

It was so agreed.

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

Dr Asadi-Lari took the Chair.

Strengthening of palliative care as a component of integrated treatment throughout the life course: Item 15.5 of the Agenda (Documents A67/31 and EB134/2014/REC/1, resolution EB134.R7)

Mr AL ATAWI (Bahrain) said that the provision of palliative care required political and regulatory reform at country level to bring national standards into line with international standards. Palliative care should be included in the initial training and continuing education of nurses, doctors and pharmacists, and the necessary medicines must be made available. WHO should provide the technical support needed to introduce palliative care into national health systems at all levels, including primary health care and home-based care, and assist with capacity-building for staff working in palliative care. He supported the draft resolution contained in resolution EB134.R7.

Dr AMMAR (Lebanon) suggested that the magnitude of the unmet needs for palliative care reflected in the Secretariat's report was the result of deficiencies in both demand and supply. Health service delivery systems were fragmented and did not reflect the concepts of case management and the continuum of care, and appropriate financing mechanisms were needed. Palliative care should be part of universal health coverage and include psychological and spiritual support, as well as the management of pain and other distressing symptoms.

Mr QASEM (Jordan) said that his country's health ministry had adopted palliative care as one of the main pillars of the national plan to combat cancer. Legislative amendments were being adopted which would enable cancer patients to obtain palliative medicines, and palliative care was beginning

to be provided both in patients' homes and in specialized units in some hospitals. He supported the draft resolution.

Mr CORRALES HIDALGO (Panama) said that, for the first time, palliative care was treated in the draft resolution as a crucial element of health systems, applicable to a wide range of noncommunicable diseases, communicable diseases such as HIV/AIDS and drug-resistant tuberculosis, and paediatric diseases. The draft resolution had been supported by a very broad range of Member States, which showed the degree of consensus on the need to strengthen and extend palliative care.

Ms GIMÉNEZ MAROTO (Spain) said that, in order to facilitate access to palliative care, policies were needed to strengthen health systems and incorporate palliative care into the whole continuum of care. Spain was drafting a document on paediatric palliative care which would set out criteria to promote such care throughout the country.

Mr ESCOBEDO (Guatemala) said that his country wished to be included as a sponsor of the draft resolution.

Mr AL KALBANI (Oman) said that palliative care not only helped to minimize the suffering of patients and their families but also reduced the cost of treatment in other health facilities. Greater care must be taken to monitor the production, import, storage and prescription of analgesics, particularly morphine, as their misuse could lead to addiction.

Ms ANDERSSON (Sweden), speaking on behalf of the Nordic countries, Denmark, Finland, Iceland, Norway and Sweden, noted that palliative care involved much more than the appropriate and strictly controlled use of drugs. For example, talking with trained staff could bring great mental relief and comfort to patients and their relatives. She asked for Denmark, Finland, Iceland, Norway and Sweden to be added to the list of sponsors of the draft resolution.

Dr SHOHANI (Iraq) believed that guidelines were needed on palliative care for chronic diseases generally, and for cancer in particular, in order to ensure its integration into primary health care. There was also a need for national, regional and international policies and strategies and for training courses, workshops and conferences to raise awareness of palliative care.

Dr GÓLCHEER-VALVERDE (Costa Rica) asked for his country to be included as a sponsor of the draft resolution. Costa Rica had long experience of palliative care, as 97% of the population was covered by the social security system and palliative care could therefore be provided free of charge. Representatives of other Member States were welcome to visit Costa Rica and learn from its experiences.

Dr ZHOU Jun (China) said that his country had increased the accessibility of analgesics and provided guidelines on pain treatment and palliative care, although much still remained to be done. He expressed his approval of the draft resolution, particularly welcoming the reference to economic support and guidance for low- and middle-income countries.

Dr SHAHANIZAN MOHD ZIN (Malaysia) said that, if palliative care was delivered in low- and middle-income countries in culturally appropriate ways with close community involvement, it could achieve outcomes similar to those in high-income countries.

Dr ALDOWAIRY (Kuwait) said that the main obstacles to obtaining palliative care were the fact that health policies did not reflect palliative care needs; the lack of relevant research and training; a lack of awareness and knowledge of palliative care among health professionals; shortages of opioid

analgesics; and financial obstacles and barriers in the health system. It was important to reform policies and regulations in countries in order to bring them into line with international standards, so that pain relief could be given to those who needed it. Palliative care and pain relief should be included in the training of health professionals, especially doctors, nurses and pharmacists, and in their continuing professional education.

Ms HEYWARD (Australia) said that, while maintaining appropriate controls, it was important to ensure access to controlled medicines for scientific and medical purposes, particularly the relief of pain and suffering. Indicators should be drawn up to measure access to palliative care in the context of the framework for monitoring progress towards universal health coverage.

Ms BALAS (Germany) said that palliative care was not an option but a social responsibility and should be an essential part of any health system. She asked for her country to be included as a sponsor of the draft resolution.

Mrs OKPESEYI (Nigeria) said that palliative care was currently available in nine tertiary health facilities in her country, and the cost of the required medicines had been reduced by 85% to 90%. Health care professionals were receiving training in palliative care both in Nigeria and in other countries.

Mr VON KESSEL (Switzerland) noted a particularly important aspect of the draft resolution, namely improving access for legitimate medical purposes to medicines referred to in the United Nations international drug control conventions. He encouraged WHO, the Commission on Narcotic Drugs of the United Nations Economic and Social Council and INCB to work together to improve access to such medicines and encourage their appropriate use.

Ms MISCIO (Italy) said that her country's policy and legislation on palliative care affirmed the right of patients to receive palliative care and pain treatment and focused on the treatment of children. Palliative care was integrated into other health care sectors, and the use of narcotic drugs for pain relief was closely monitored.

Mr PIPPO (Argentina) outlined the steps that his country's national cancer institute was taking to introduce a model of palliative care that catered to the specific needs of cancer patients and their families. At provincial level, surveys were being carried out to obtain updated information on available resources, specific needs for palliative care and barriers to access. Policies were being implemented to train human resources in palliative care services for cancer patients.

Ms BURRIS (United States of America), commending Panama on its leadership in preparing the draft resolution contained in resolution EB134.R7, said that her country regarded palliative care as integral to any health system and welcomed its inclusion in the definition of universal health coverage. The integration of palliative care services, including psychosocial and spiritual support, into the continuum of care called for effective training and support for carers. Meanwhile, continued collaboration with INCB and the Commission on Narcotic Drugs of the United Nations Economic and Social Council was required in order to ensure greater access to the controlled substances needed to relieve pain and suffering, backed up by measures to prevent their diversion and abuse.

Mr KIM Young-hak (Republic of Korea) called on WHO to develop and disseminate a model of palliative care. Each country should provide care that was in keeping with the available resources and local disease patterns and introduce training programmes for the relevant health workers, and attention should be paid to reviewing guidelines and considering the possible adoption of a monitoring framework to measure accessibility and uptake of palliative care services by patients.

Dr PRIHARUM MARLINA (Indonesia) said that Indonesia was aware of the need to strengthen palliative care, including psychosocial and spiritual support, so as to allow the increasing numbers of patients in the terminal phase of illness to die with dignity. Regulations had been introduced on the scope and provision of palliative care services, guidelines had been drafted for palliative nursing and the treatment of late-stage cancer patients, and access to palliative care and controlled drugs in hospitals had been included in a national social health insurance scheme intended, ultimately, to provide universal health coverage. However, the regulations and guidelines had yet to be extended to community and home-based care, and more needed to be done to enhance the capacity of health care workers, foster collaboration with families and other carers, and increase cross-sector cooperation in order to improve access to high-quality medicines.

Dr UGRID MILINTANGKUL (Thailand) called on Member States to include palliative care as a component of comprehensive national health services and urged WHO to promote the use of opioid analgesics, with suitable indicators to monitor that use. Given that palliative care was generally used when a cure was no longer possible and that it involved other physical, psychosocial and spiritual aspects of health care, as well as a role for actors outside the health sector, he suggested that the words “integrated treatment” in the title of resolution EB134.R7 should be replaced by “comprehensive care”.

Mrs MATTHES (Samoa) stressed the importance of adapting the actions set out in paragraph 20 of the Secretariat’s report to the conditions and needs prevailing at the national level. Committed leadership and governance were required for effective and efficient palliative care, and she called on WHO to provide continued support.

Dr ACENG (Uganda) said that her country’s Ministry of Health was currently finalizing a national palliative care policy. Uganda had one of the best palliative care education systems in Africa, with relevant courses forming part of pre-service training for most health professionals. Oral morphine was provided free of charge for any patient who needed it, in strict observance of all the regulations governing the use of narcotic drugs for medical purposes.

Mrs ANDRIENKO (Ukraine) asked for her country to be included as a sponsor of the draft resolution. Palliative care should be recognized as a human right in order to give terminally ill people, especially children, the chance to end their lives without pain. INCB had recognized the need to strike the right balance between access and control. Ukraine had already introduced legislation to that end and had begun producing its own morphine in tablet form. However, more work needed to be done to raise awareness of the delivery of home-based palliative care and the effects of pain management drugs, as well as to counter the use of unregistered forms of morphine. Ukraine was grateful for the methodological and technical support received from international partners.

Mrs NDLELA-SIMELANE (Swaziland), speaking on behalf of the Member States of the African Region, said that, in spite of the increasing need for palliative care in Africa owing to the continent’s double burden of communicable and noncommunicable diseases, existing models for the provision of services remained small-scale and had yet to be integrated into health systems. A harmonized response would require more work on the part of WHO and other relevant organizations of the United Nations system, and its sustainability would rely on leadership in the countries concerned.

The Member States in her Region supported the draft resolution, with the addition of new subparagraphs calling on both Member States and the Director-General to promote action on palliative care for children.

Dr ETALEB (Libya) said that his country regarded palliative care as crucial for improving the quality of life of patients with life-threatening illnesses. Placing particular emphasis on the provisions related to the availability and appropriate use of internationally controlled medicines, he called on other Member States to support the draft resolution.

Dr SHAKEELA (Maldives) said that palliative care faced many challenges in the South-East Asia Region, ranging from misconceptions or a lack of awareness through to inadequate health policies and research. The demand for palliative care was growing on account of the increasing numbers of people who were living longer with life-threatening conditions. Anticipating their needs and offering the necessary care would ensure that they had a better quality of life and a greater chance of dying with dignity in the setting of their choice.

Dr NGUYEN MANH CUONG (Viet Nam) said that his country's national palliative care initiative had, with international financial and technical support, made progress in improving regulations for the prescription of opioids, training health care professionals, and initiating services in hospitals and at the community level. However, access to care remained limited. He therefore endorsed the list of actions that Member States were urged to take in the draft resolution and called on WHO to support the adaptation of guidelines and tools for its implementation.

Ms GONÇALVES (Brazil) noted the importance of striking a balance between access to and control of palliative care medicines for medical and scientific purposes in accordance with the international drug control conventions. Her country would continue to manufacture its own medicines and introduce new technology to guarantee access to medicines for millions of its citizens free of charge. However, it was equally important to tackle other subjects, such as the training of health care professionals and support for the elderly and their families and carers.

Mr SMITH (Trinidad and Tobago) commended the Secretariat's comprehensive report that set out the key components of a national palliative care programme as part of universal health coverage in both resource-rich and resource-constrained settings. Trinidad and Tobago had been working in partnership with nongovernmental organizations to meet the increasing demand for palliative care services and fully supported the draft resolution.

Ms GARCÍA ARREOLA (Mexico) asked for her country to be included as a sponsor of the draft resolution. The strengthening of palliative care as a component of integrated treatment throughout the life course was crucial, in view of the impact of the illnesses in question on health budgets.

Mr BAHER MOHAMED (Egypt) said that Egypt considered palliative care to be as high a priority as preventive and curative health care, and the quality of a person's life to be as important as its length. Nongovernmental organizations should advocate for access to palliative care for all patients, with particular emphasis on education and awareness-raising, and Member States should implement national policies to promote such services as a component of universal health coverage.

Ms GIMÉNEZ LEÓN (Paraguay) said that palliative care should go much further than provision of the narcotic pain-relieving drugs traditionally supplied to a limited group of patients in the terminal phase of illness. Her Government provided palliative care services for patients and support for their families in family health clinics, especially in marginalized areas, as part of its universal primary health care strategy. She supported the draft resolution and requested that Paraguay be added to the list of sponsors.

Ms ALARCÓN MAYORGA (Colombia) stressed that palliative care was crucial to coping with the burden of disease and, hence, to the right to health. In addition to the measures highlighted in the Secretariat's report, palliative care should be regarded as an integral part of all primary health care strategies. Opioids and similar medicines should be included in joint price negotiations for medicines, and further action should be considered in the areas of pharmacovigilance, inspection and control in order to prevent abuse.

Dr Wui-Chiang LEE (Chinese Taipei) said that the successful provision of palliative care relied on changing people's attitudes to end-of-life care and on cooperation with nongovernmental organizations, medical societies and health insurance companies. Chinese Taipei was ready to share its experience in that area with Member States.

Mr MIRANDA (International Federation of Medical Students' Associations), speaking at the invitation of the CHAIRMAN and also on behalf of The World Medical Association, Inc. and the World Organization of Family Doctors, expressed support for the draft resolution and for Member States in developing policies to integrate equitable palliative care services into the continuum of care; to allow health care professionals and patients to have access to a ready supply of opioids; to include education on palliative care in all undergraduate medical and nursing curricula; and to ensure adequate resources for palliative care initiatives developed by organizations specializing in that field.

Mr ADAMS (Union for International Cancer Control), speaking at the invitation of the CHAIRMAN and also on behalf of the European Society for Medical Oncology, said that palliative care was an essential health service for people with chronic, life-limiting illnesses. Particular attention should be paid to integrating palliative care standards and policies into health systems and into national plans to control noncommunicable diseases; to providing training and education adapted to local settings; to reviewing legislation and policies on controlled medicines; and to updating national lists of essential medicines.

Dr LUXFORD (Alzheimer's Disease International), speaking at the invitation of the CHAIRMAN, emphasized the fact that without access to palliative care, people with Alzheimer's disease and other irreversible dementias faced debilitating symptoms and their families, acting as carers, were often left with no support. Her organization therefore welcomed the draft resolution.

Dr CONNOR (International Association for Hospice and Palliative Care Inc.), speaking at the invitation of the CHAIRMAN, called on all Member States to implement fully the recommendations in the draft resolution.

Dr KIENY (Assistant Director-General) said that it was encouraging to see so many Member States wishing to sponsor the draft resolution contained in resolution EB134.R7, the first-ever World Health Assembly resolution on palliative care. The Secretariat had noted the request that palliative care should be regarded as a component of person-centred, integrated health services. WHO promoted equitable access to effective and safe medicines for palliative care. Working closely with the United Nations Office on Drugs and Crime and INCB, it supported countries around the world in developing balanced policies for controlled medicines, so as to ensure access to needed medicines while preventing nonmedical use and diversion of controlled substances. The Secretariat had noted the delegate of Australia's request that WHO's framework for monitoring progress towards universal health coverage should include an indicator to assess access to palliative care. Further noting the request by the delegate of Swaziland, on behalf of the Member States of the African Region, that special action should be taken and partnerships established in support of palliative care for children, she drew attention to relevant provisions in subparagraphs 1(8) and 2(8) of the draft resolution.

Mr CORRALES HIDALGO (Panama), thanking the various speakers for their interest in and support for the draft resolution proposed by his country, said that he shared the concerns of the delegate of Swaziland in regard to the provision of palliative care for children but, as indicated by the Assistant Director-General, those concerns were already clearly reflected in various parts of the document. There was no need to include a new subparagraph in the draft resolution.

Dr PHUSIT PRAKONGSAI (Thailand) reiterated his country's request that the words "integrated treatment" in the title of resolution EB134.R7, which suggested a focus on services provided by health care professionals in a health facility setting, should be replaced by "comprehensive care".

The draft resolution, as amended, was approved.¹

Dr Akauola resumed the Chair.

Regulatory system strengthening: Item 15.6 of the Agenda (Documents A67/32 and EB134/2014/REC/1, resolutions EB134.R17 and EB134.R19) (continued from the third meeting of Committee A, section 5)

Mr PIPPO (Argentina), speaking with reference to the draft resolution contained in resolution EB134.R19, requested that an operative paragraph, mistakenly deleted in the course of regional consultations following the 134th session of the Executive Board, should be reinserted into the document. The paragraph in question should read as follows: "to work to ensure that the introduction of new national regulations, where appropriate, does not constitute a barrier to access to quality, safe, efficacious and affordable biotherapeutic products, including similar biotherapeutic products;".

Dr MBOFANA (Mozambique), speaking on behalf of the Member States of the African Region, recommended the adoption of the draft resolution contained in resolution EB134.R17. African countries, recognizing that the effective regulation of medicines was crucial to the promotion and protection of public health, were striving to establish national regulatory authorities with the capacity, resources and legal mandate to ensure that all medical products met the requisite standards of quality, safety and efficacy. In many countries, however, the regulatory systems were still too weak and incapable of preventing the proliferation of counterfeit products. The favoured approach at present was to establish a regional medicines agency with the involvement of regional economic communities and the African Union Commission.

Mr TOGI HUTADJULU (Indonesia) said that his Government was committed to protecting the public from the risks associated with substandard, counterfeit and illegal medical products by ensuring that all medicines and technologies complied with international standards of quality, safety and efficacy, and to promoting access to approved products through a strengthened global regulatory system.

Dr TRAN THI MAI OANH (Viet Nam) urged the Secretariat to support developing countries and others in ensuring that the provisions in some current trade agreements did not undermine the independence of national regulatory authorities. The latter must not be used to advance commercial interests.

¹ Transmitted to the Health Assembly in the Committee's third report and adopted as resolution WHA67.19.

Mr DENEKEW (Ethiopia) supported the introduction of modular core curricula for training regulators and the fostering of regulatory convergence and harmonization through collaboration with WHO and relevant partners. Such measures were in keeping with his Government's own policies and approaches.

Mr SILLO (United Republic of Tanzania), drawing attention to the efforts being made in his country and subregion to address the challenges described in the Secretariat's report, said that functional regional regulatory authorities and networks provided the foundations for enhancing and transitioning the WHO prequalification programme from WHO itself to the national level.

Ms VALDEZ (United States of America), referring to the draft resolution contained in resolution EB134.R19, said that the development of similar biotherapeutic products might help to address the problem of access to biotherapeutics, but a scientifically based review of reference biotherapeutic products would need to be completed first. Rigorous, scientifically based regulatory standards were crucial in order to avoid the emergence of different quality standards. She supported the amendment proposed by the delegate of Argentina.

Dr HARTIGAN-GO (Philippines) said that human resource development and financial requirements should receive adequate political and administrative support, in order to promote the strengthening of national regulatory systems and the delivery of health services. A sensible balance had to be struck between health outcomes and economic objectives, including those related to cross-border trade, while the balance between innovation and sound regulation could be attained through strong scientifically based principles aimed at improving public health outcomes.

Mr QUINTANA ARANGUREN (Colombia) said that his country, like most others, faced significant challenges in promoting the use of costly biotherapeutic products. Given that many of the patents on those products were due to expire in the coming years, however, more competitive products would soon be appearing on the market which, together with the development of national and regional production capacity and technology transfers, should ease the financial burden and help countries to attain the goals of accessibility and universal health coverage.

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

The meeting rose at 17:30.

SIXTH MEETING

Saturday, 24 May 2014, at 09:40

Chairman: Dr R. RUGUNDA (Uganda)

1. ORGANIZATION OF WORK

The CHAIRMAN suggested that, owing to time constraints, delegates should ensure that their statements focused on draft resolutions that required the Committee's consideration. He also suggested that, in order to ensure that the Committee could complete its work, item 17 of the agenda should not be taken up, since the progress reports had already been considered by the Executive Board at its 134th session.

Ms VALLINI (Brazil), Mr VEGA MOLINA (Spain), Mr MAMACOS (United States of America), Mr ESIN (Russian Federation), Dr SANON (Burkina Faso), Professor NAPO-KOURA (Togo), Mr JAIN (India) and Mr DIALLO (Mali) said that they wished to make statements regarding the progress reports under item 17 and requested that the Committee consider the item.

The CHAIRMAN took it that the Committee wished to take up item 17 at a later stage.

It was so agreed.

(For discussion of item 17, see the summary record of the twelfth meeting of Committee A, section 9.)

2. THIRD REPORT OF COMMITTEE B (Document A67/71)

Dr SINGH (Nepal), Rapporteur, read out the draft third report of Committee B.

The report was adopted.¹

3. HEALTH SYSTEMS: Item 15 of the Agenda (continued)

Follow-up of the report of the Consultative Expert Working Group on Research and Development: Financing and Coordination: Item 15.2 of the Agenda (Documents A67/27, A67/28 and A67/28 Add.1) (continued from the fourth meeting, section 2)

The CHAIRMAN drew attention to an amended version of a draft decision on the item, proposed by the delegation of France, which read:

¹ See page 350.

The Sixty-seventh World Health Assembly, having considered the follow-up **report** ~~reports~~ of the Consultative Expert Working Group on Research and Development Financing and Coordination,¹

(1) ~~noted welcomed~~ the progress made in implementation of resolution WHA66.22 and decision EB134(5);

(2) **recognized** ~~endorsed~~ the indicators to measure success in implementing the health research and development demonstration projects **and requested the addition of an analysis of the extent of innovative components being implemented by the projects including financing, the use of open access models, multisectoral research platforms, and delinkage, among other criteria;**

(3) requested the Director-General to expedite the process of the remaining four projects, in addition to the four already agreed, and to report progress to the 136th session of the Executive Board; ~~and~~

(4) ~~noted among other options, the assessment of the~~ **noted, without prejudice to future discussions in the context of CEWG recommendations and actions on other sustainable mechanisms for financing health research and development, the assessment made by the Secretariat and the possibility of using an existing mechanism to host a pooled fund for voluntary contributions towards research and development for diseases that disproportionately affect type III and II diseases and the specific research and development needs of developing countries, and requested in relation to type I diseases;**

(5) **requested** the Director-General to further explore ~~the~~ **this** option with TDR, ~~take appropriate action and submit a report to~~ **including** the ~~Sixty-eighth World Health Assembly~~ following elements:

- **recognizing that the scope of the diseases should not be limited to type III diseases but should be in line with the GSPA-PHI mandate;**
- **recognizing the need for a sustainable financial mechanism for health R&D;**
- **recognizing the role of Member States in the governance of the coordination mechanism;**

(6) **requested the Director-General to report to the Sixty-eighth World Health Assembly through the 136th session of the Executive Board with reference to this decision.**

The CHAIRMAN said that, in the absence of any objection, he took it that the Committee wished to approve the draft decision, as amended.

The draft decision, as amended, was approved.²

¹ Documents A67/27, A67/28 and A67/28 Add.1.

² Transmitted to the Health Assembly in the Committee's fourth report and adopted as decision WHA67(15).

Access to essential medicines: Item 15.4 of the Agenda (Documents A67/30 and EB134/2014/REC/1, resolution EB134.R16) (continued from the fifth meeting)

The CHAIRMAN drew attention to a revised version of the draft resolution recommended by the Executive Board in resolution EB134.R16, incorporating amendments by Bhutan, India, Oman, Syrian Arab Republic and Viet Nam, and which read:

The Sixty-seventh World Health Assembly,

PP1 Having considered the report on access to essential medicines;

PP2 Noting that WHO's definition of an essential medicine¹ contains the following elements: "Essential medicines are those that satisfy the priority health care needs of the population" and "Essential medicines are selected with due regard to their public health relevance, evidence of efficacy and safety, and comparative cost-effectiveness";

PP3 Recalling resolution WHA28.66 on prophylactic and therapeutic substances that relates to the formulation and implementation of medicines policies and pharmaceutical strategies; the Declaration of Alma-Ata in 1978 that recognized the provision of essential medicines as one of the pillars of primary health care, and subsequent resolutions in relation to essential medicines, such as resolution WHA54.11 on the WHO medicines strategy, WHA58.27 on improving the containment of antimicrobial resistance, WHA60.16 on progress in the rational use of medicines, WHA60.20 on better medicines for children, WHA60.29 on health technologies, WHA61.21 on the global strategy and plan of action on public health, innovation and intellectual property, and WHA64.9 on sustainable health financing structures and universal coverage, as well as WHA66.10 in which the Health Assembly endorsed the WHO global action plan for the prevention and control of noncommunicable diseases 2013–2020, and which includes Target (9) on the availability of essential medicines required to treat noncommunicable diseases;

PP4 Bearing in mind that the WHO medicines strategy, as set out in the Twelfth General Programme of Work 2014–2019, is based on the principles of evidence-based selection of a limited range of medicines, efficient procurement and distribution systems, affordable prices, and the rational use of medicines in order to promote better management and greater availability of medicines, more cost-effective use of health resources, and higher quality health care;

PP5 Considering that the effective implementation of the above principles is of critical importance to improving people's health, progressing towards universal health coverage and achieving the health-related Millennium Development Goals;

PP6 Welcoming WHO's regional actions in support of greater access to – and availability, affordability and rational use of – safe, effective and quality-assured essential medicines, including development of the Regional Office for the Western Pacific Regional Framework for Action on Access to Essential Medicines (2011–2016);

PP7 Acknowledging the complexity of the medicines supply chain and the challenges that countries encounter in this regard, the importance of good governance for medicines programmes,² and the consequences of the high costs of medicines, which are among the factors that make accessing care and treatment unaffordable;

¹ WHO Expert Committee on the Selection and Use of Essential Medicines. Geneva: World Health Organization; in press (WHO Technical Report Series, No 985).

² In WHO's assessment instrument for measuring transparency in the public pharmaceutical sector (document WHO/EMP/MAR/2009.4), "good governance" refers to the formulation and implementation of appropriate policies and procedures that ensure the effective, efficient and ethical management of pharmaceutical systems, in particular medicines regulatory systems and medicine supply systems, in a manner that is transparent, accountable, follows the rule of law and minimizes corruption.

PP8 Aware that shortages of essential medicines are a global problem that has an impact on the care of patients, the causes and implications of which vary from one country to another, and that there is insufficient information to determine the magnitude and specific characteristics of the problem;

PP9 Realizing the role of evidence-based clinical treatment guidelines to guide cost-effective treatment practices, the need for reliable and unbiased information to support rational prescribing, and the importance of increased health literacy to support patients and consumers to use medicines wisely;

PP10 Noting with concern that despite sustained efforts over a number of decades by Member States, the Secretariat and partners, most low-income countries are still facing a multitude of challenges in improving the availability, affordability and rational use of essential medicines;

PP11 Noting that the goal of Member States is to increase access to affordable, safe, effective and quality-assured essential medicines, including as appropriate, through the full use of the flexibilities in the Agreement on Trade-Related Aspects of Intellectual Property Rights in line with the Global Strategy and Plan of Action on Public Health Innovation and Intellectual Property;

PP12 Noting that support for research and development is important for the sustainable supply of future essential medicines, to address public health needs,

(OP.1) URGES Member States:¹

(OP1.1) to ~~recognize the need and~~ [Bhutan] provide adequate resources, as required, for the development **and implementation [Bhutan]** of comprehensive national medicine policies, **to strengthened good governance of [Bhutan]** pharmaceutical **systems including [Bhutan]** regulatory, procurement and distributions systems and **to coordinated [Bhutan]** responses to address the complex and interrelated activities that affect access to essential medicines, in order to improve their availability, affordability, quality and rational use;

(OP1.2) to improve national policies for selection of essential medicines, **including critical medicines, [India]** particularly by using transparent, rigorous, evidence-based processes based on the methods of health technology assessment in selecting medicines for inclusion in the national essential medicines lists according to each country's health needs and priorities;

(OP1.3) to encourage and support research on health systems regarding the procurement, supply and rational use of essential medicines;

(OP1.4) to promote collaboration and strengthen the exchange of information on best practices in the development, implementation and evaluation of medicine policies and strategies, that enhance access to affordable, safe, effective and quality-assured essential medicines;

(OP1.5) to place greater emphasis on medicines for children and to promote the availability, affordability, quality and safety of essential medicines for children through the development and manufacture of appropriate paediatric formulations and to facilitate market access to these medicines;

(OP1.6) to improve the education and training of health care professionals in order to support the implementation of national policies and strategies in relation to essential medicines, and to develop and implement evidence-based clinical practice guidelines and other interventions for the rational use of essential medicines;

(OP1.7) to strengthen the engagement with the general public and civil society to increase awareness and knowledge of essential medicines and public involvement,

¹ And, where applicable, regional economic integration organizations.

as appropriate, and through transparent mechanisms and structures, [Viet Nam] in enhancing access to and the rational use of these medicines;

(OP1.8) to identify key barriers to access to essential medicines and to develop strategies to address these barriers, making use of WHO's tools¹ and guidance as appropriate;

(OP1.9) to establish or strengthen, as appropriate, systems to monitor the availability **(using effective inventory management systems) [Bhutan]**, affordability and utilization of safe, effective and quality-assured essential medicines in public and private health facilities;

(OP1.10) to systematize information collection and strengthen monitoring mechanisms, in order to better detect and understand the causes of essential medicines shortages, and to develop strategies to prevent and mitigate the associated problems and risk caused by shortages;

(OP1.11) to prevent countries in crisis to suffer from economic sanctions that will limit access to essential medicines and to ingredients for local production of medicines; [Syrian Arab Republic]

(OP1.12) to consider, as appropriate, adapting national legislation in order to make full use of the provisions contained in the Agreement on Trade-Related Aspects of Intellectual Property Rights, including the flexibilities recognized by the Doha Ministerial Declaration on the TRIPS Agreement and Public Health and other WTO instruments related to that agreement, in order to promote access to essential medicines, in line with the Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property;

(OP.2) REQUESTS the Director-General:

(OP2.1) to urge Member States to recognize the importance of effective national medicines policies, and their implementation under good governance, in order to ensure equity of access to affordable, safe, effective and quality-assured essential medicines and their rational use in practice;

(OP2.2) to facilitate and support the exchange of information and collaboration among Member States on best practices in the development and implementation of medicines policies;

(OP2.3) to support Member States in sharing best practices in the selection of essential medicines, and facilitating collaboration between the Secretariat and Member States in developing processes for the selection of medicines for national essential medicines lists consistent with the evidence-based methods used for updating the WHO Model List of Essential Medicines;

(OP2.4) to support Member States in building capacity for the evidence-based selection of essential medicines, the development and dissemination of, and adherence to, clinical practice guidelines and the promotion of other strategies for the rational use of affordable, safe, effective and quality-assured essential medicines by health care professionals and the public;

(OP2.5) to support Member States in developing and implementing their national medicines policies and supply systems especially with regard to regulation, financing, selection, procurement, distribution, pricing, reimbursement and use, in order to increase their efficiency and ensure the access to safe, effective and quality-assured essential medicines, including high price essential medicines;

¹ Including but not limited to: pharmaceutical sector country profiles, the assessment instrument for measuring transparency in the public pharmaceutical sector, the WHO/Health Action International tool for measuring medicine prices, availability, affordability and price components, and guidance on how to investigate drug use in health facilities.

(OP2.6) to support Member States in systematizing information collection and strengthening monitoring mechanisms, in order to better detect and understand the causes of essential medicines shortages, and in developing strategies to prevent and mitigate the associated problems and risk caused by shortages;

(OP2.7) to urge Member States to expedite progress towards the achievement of the Millennium Development Goals and universal health coverage by, inter alia, implementing national medicines policies for improving access to affordable, safe, effective, and quality-assured essential medicines;

(OP2.8) to provide, as appropriate, upon request, in collaboration with other competent international organizations, technical support, including, where appropriate, to policy processes to Member States that intend to make use of the provisions contained in the Agreement on Trade-Related Aspects of Intellectual Property Rights, including the flexibilities recognized by the Doha Ministerial Declaration on the TRIPS Agreement and Public Health and other WTO instruments related to that Agreement, in order to promote access to essential medicines, in accordance with the Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property;

(OP2.9) to review/improve, in collaboration with other relevant organizations, procedures needed by Member States to implement the flexibilities within TRIPS and make these procedures more flexible. [Oman]

(OP2.10⁹) to report to the Sixty-ninth World Health Assembly, through the Executive Board, on the implementation of this resolution.

Dr NITHIMA SUMPRADIT (Thailand) asked for clarification of the term “critical medicines” that had been introduced in subparagraph (OP1.2) by an amendment from the delegation of India.

Mr MAMACOS (United States of America) said that he could not accept the proposed amendment to subparagraph (OP1.2), since it was unclear what was meant by the term “critical medicines”. The amendment did not appear to be in line with the scope of the draft resolution, which focused on essential medicines. The proposed new subparagraph (OP1.11) could not be accepted either, since it would raise policy issues in relation to sanctions that could not be resolved at the current Health Assembly. Subparagraph (OP2.9) was largely redundant because of its similarity to subparagraph (OP2.8) and was also not acceptable.

Dr REN Minghui (China) said that the meaning of the phrase “critical medicines” in subparagraph (OP1.2) remained unclear and therefore suggested that the phrase should be deleted. The proposal by the Syrian Arab Republic for a new subparagraph (OP1.11) was not a matter for the Committee, since it had already been discussed by the United Nations General Assembly. Given its similarity to subparagraph (OP2.8), subparagraph (OP2.9) should be deleted.

Mr COTTERELL (Australia) asked for clarification from both the delegation of India and the Secretariat of the meaning of the term “critical medicines” in subparagraph (OP1.2). He had some difficulties with the text of subparagraph (OP1.11); further discussion was required on that matter. Since subparagraph (OP2.9) duplicated subparagraph (OP2.8), he would prefer to retain the text of the latter.

Ms KEKEMPANOU (Greece), speaking on behalf of the European Union and its Member States, supported the proposals by other delegations to delete the proposed amendments in subparagraphs (OP1.2), (OP1.11) and (OP2.9).

Dr OKABAYASHI (Japan) agreed with previous speakers that subparagraph (OP2.9) was superfluous.

Dr GYANSA-LUTTERODT (Ghana) noted that the phrase “critical medicines” would need to be defined if it was to be introduced in subparagraph (OP1.2).

Mr JAIN (India), responding to the concerns raised about the meaning of the term “critical medicines”, said that it had been introduced to reflect the fact that the inclusion of many medicines that might be critical to public health needs in particular countries could contribute to the aim of improving national policies for the selection of essential medicines, even though they did not meet WHO’s definition of essential medicines. However, he was prepared to propose alternative wording for the amendment, namely “and other medicines critical to public health needs” instead of “including critical medicines”.

Dr AL HINAI (Oman) said that his delegation had decided to withdraw its proposal for a new subparagraph (OP2.9).

The CHAIRMAN took it that the Committee wished to suspend discussion of the item in order to allow time for the delegation of the Syrian Arab Republic to consider its position on its proposed amendment.

It was so agreed.

(For resumption of the discussion, see page 317.)

Regulatory system strengthening: Item 15.6 of the Agenda (Documents A67/32 and EB134/2014/REC/1, resolutions EB134.R17 and EB134.R19) (continued from the fifth meeting)

The CHAIRMAN drew attention to a revised version of the draft resolution contained in resolution EB134.R17, incorporating amendments proposed by various delegations, which read:

The Sixty-seventh World Health Assembly,

Welcoming the efforts of the Director-General, and recognizing the pivotal role that WHO plays in supporting countries in strengthening their regulatory systems of medical products for human use,¹ and in promoting equitable access to quality, safe, efficacious, and affordable medical products;

Recalling the Constitution of the World Health Organization, which affirms 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;

Recalling also United Nations General Assembly resolution 67/81 on global health and foreign policy, which, inter alia, recognized the importance of universal coverage in national health systems, especially through primary health care and social protection mechanisms, in the provision of access to health services for all, in particular for the poorest segments of the population;

Recalling further resolutions WHA45.17, WHA47.17, WHA52.19, WHA54.11, WHA59.24, WHA63.12, and WHA65.19, all of which encompass aspects of the need to promote the quality, safety, efficaciousness and affordability of medicines, including blood products;

¹ For the purpose of this resolution, medical products include medicines, vaccines, diagnostics and medical devices.

{Reaffirming resolution WHA65.19, which establishes a new Member State mechanism for international collaboration, from a public health perspective, EXCLUDING TRADE AND INTELLECTUAL PROPERTY CONSIDERATIONS, to prevent and control substandard/spurious/falsely-labelled/falsified/counterfeit medical products and to promote access to affordable, safe and quality medical products;}

Recognizing that effective regulatory systems are an essential component of health systems strengthening and contribute to better public health outcomes, that regulators are an essential part of the health workforce, and that inefficient regulatory systems themselves can be a barrier to access to safe, effective and quality medical products;

Recognizing also that effective regulatory systems are necessary for implementing universal health coverage, responding to the dual burden of infectious and noncommunicable diseases, and achieving Millennium Development Goal 4 (Reduce child mortality) Goal 5 (Improve maternal health) and Goal 6 (Combat HIV/AIDS, malaria and other diseases);

Aware that health systems need to promote access to essential medical products and that, in order to ensure universal access to health care, rational use of medicines and the sustainability of health systems, urgent action is needed by the international community, Member States and relevant actors in health systems;

Very concerned by the impact on patients of medical products of compromised quality, safety and efficacy, in terms of poisoning, inadequate or no treatment, contributions to drug resistance, the related economic burden, and erosion of public trust in the health system;

{Aware of the regulatory challenges presented by ever-increasing complexities of medical product global supply chains AND WELCOMING THE SSFFC MEMBER STATE MECHANISM WORK PLAN;}

Emphasizing WHO's role in strengthening regulatory systems for medical products from a public health perspective, and in supporting national drug regulatory authorities and relevant regional bodies in this area, and in particular in developing countries;

Recalling the WHO global strategy and plan of action on public health, innovation and intellectual Property, in particular element three, which calls for establishing and strengthening regulatory capacity in developing countries as one effective policy for building and improving innovative capacity, and element six, which promotes establishing and strengthening mechanisms to improve ethical review and regulate the quality, safety and efficacy of health products and medical devices;

Noting with appreciation the many **EXISTING** national and regional efforts to strengthen regulatory capacity (including through a variety of models), improve regulatory coherence and convergence among regulatory authorities, and enhance good governance, including transparency in decision-making, leading to the improved availability of quality, safe, efficacious and affordable medical products, such as the European Union regulatory framework for medical products, work under way in PAHO following its 2010 resolution CD50.R9, the African Medicines Regulatory Harmonization Initiative, and the regulatory harmonization and cooperation work in ASEAN;

~~{Also noting with appreciation~~ NOTING the ongoing collaboration between some national AND REGIONAL regulatory authorities, including at the global level, in setting standards, including the International Conference on Harmonisation of Technical Requirements for Registration of Pharmaceuticals for Human Use PROMOTING COOPERATION among others, and encouraging a continued emphasis of effort in strengthening regulatory systems in accordance with WHO principles **AUTHORITIES AT THE REGIONAL and GLOBAL LEVELguidelines;}**

Recognizing the significant investments made in the procurement of medicines through ~~global health initiatives~~, national health budgets, and **GLOBAL HEALTH INITIATIVES**; ~~in particular,~~

ALSO RECOGNIZING the essential role of WHO's prequalification programme ~~and national~~ **IN FACILITATING PROCUREMENT OF MEDICAL PRODUCTS WITH ASSURED QUALITY, SAFETY AND EFFICACY;**

STRESSING THAT STRENGTHENING OF regulatory systems ~~in—assuring~~ **SHOULD COMPLEMENT** the ~~safety, quality and efficacy~~ **EFFORTS** of these **WHO AND MEMBERS STATES TO PROMOTE ACCESS TO AFFORDABLE** medical products **WITH ASSURED QUALITY, SAFETY AND EFFICACY;**

Recalling the WHO good clinical practices that focus on the protection of human research subjects;

Recalling also WHO's ongoing reform agenda and welcoming in this regard the establishment in November 2012 of the Health Systems and Innovation cluster,

1. **URGES** Member States:¹

(1) to strengthen national regulatory systems, **INCLUDING THROUGH**~~by~~, as appropriate **AND VOLUNTARILY, BY:**

(a) undergoing self-evaluations, including with WHO support, to identify the strengths and opportunities for improvement in regulatory system functions, as a first step towards formulating plans for regulatory systems strengthening, including through WHO-coordinated institutional development plans;

(b) collecting data on regulatory system performance to enable analysis and benchmarking for improved systems in the future;

(c) developing strong legal foundations and political leadership to underpin a regulatory system with a clear focus on patient safety and transparency in decision-making;

(d) identifying and developing a core set of regulatory functions to meet country and/or regional needs, such as market control and postmarket surveillance;

(e) developing needed competencies as an integral part of, although not limited to, the health workforce, and encouraging the development of the regulatory field as a profession;

(f) ~~{implementing~~ **FACILITATING THE USE OF** relevant guidance and science-based outputs of WHO EXPERT COMMITTEES AND GOOD REGULATORY PRACTICES AT THE NATIONAL, REGIONAL AND international LEVEL; ~~regulatory harmonization and convergence efforts such as, where applicable, the Conference on Harmonisation of Technical Requirements for Registration of Pharmaceuticals for Human Use;}~~

(g) ~~{DEVISING AND~~ **implementing strategies to address the increasing complexities of global supply chains;}**

(2) to engage in global, regional and subregional networks of national regulatory authorities, as appropriate, recognizing the importance of collaboration to pool regulatory capacities to promote greater access to quality, safe, efficacious and affordable medical products;

(3) to promote international cooperation, as appropriate, for **COLLABORATION** ~~convergence~~ and information sharing, including through electronic platforms;

(4) to support regulatory systems for medical products with appropriate funding as an essential component of the health system;

(5) to support regulatory system strengthening as an essential **COMPONENT** ~~prerequisite~~ to the development or expansion of local or regional production of quality, safe and efficacious medical products;

¹ And, where applicable, regional economic integration organizations.

- (6) to achieve access to and rational use of quality, safe, efficacious and affordable essential medicines, noting the growing emergence of resistance, and as a foundation for achieving broader access to quality, safe, efficacious and affordable medical products;
- (7) to support WHO's institutional capacity relating to promoting access to and rational use of quality, safe, efficacious and affordable medical products in the context of universal health coverage;
- (8) ~~to support WHO in its efforts to strengthen its~~ **NATIONAL AND REGIONAL INITIATIVES OF REGULATORY AUTHORITIES TO IMPROVE REGULATORY CAPACITIES FOR REVIEW OF MEDICAL PRODUCTS AND TO PROMOTE WHO'S LONG-TERM OBJECTIVE OF SUPPORTING THE STRENGTHENING OF NATIONAL REGULATORY AUTHORITY CAPACITY AMONG MEMBER STATES;**
- (9) **TO SUPPORT WHO'S prequalification programmes, including exploring modalities in consultation with Member States¹ for improved sustainability of this critical programme, [while also focusing on supporting national and regional initiatives to improve regulatory capacity for medical products][focusing on achieving longer term objectives of developing national regulatory authority capacity among Member States];**
- (109) to identify the need to strengthen regulatory system capacity, collaboration and **COOPERATION** ~~convergence~~ in the technically complex areas where substantial gaps may still exist, such as the regulation of biotherapeutic products, blood products, and in vitro diagnostics;

2. REQUESTS the Director-General:

- (1) to continue to support countries **UPON THEIR REQUEST** in the area of regulatory system strengthening, including, **AS APPROPRIATE**, by ~~developing appropriate norms and standards[, taking into account the standards created by existing regional and international initiatives];~~ **continue CONTINUING TO:**
- (a) evaluate national regulatory systems; ~~continue to~~
 - (b) apply ~~and improve~~ WHO evaluation tools; ~~continue to~~
 - (c) generate and analyse evidence of regulatory systems performance; ~~continue to~~
 - (d) facilitate the formulation and implementation of institutional development plans; and ~~continue to~~
 - (e) provide technical support to national regulatory authorities and governments;
- (2) **TO CONTINUE TO DEVELOP APPROPRIATE NORMS, STANDARDS AND GUIDELINES, INCLUDING TAKING INTO ACCOUNT NATIONAL, REGIONAL AND INTERNATIONAL NEEDS AND INITIATIVES, IN ACCORDANCE WITH WHO PRINCIPLES;**
- (32) to ensure that all relevant parts of the Organization, at all levels, are actively engaged and coordinated in the carrying out of WHO's mandate pertaining to regulatory system strengthening as an integrated part of health system development, recognizing that WHO's support in this critical area, particularly for developing countries, may be required, as appropriate, well into the future;
- (43) to prioritize support for establishing and strengthening regional and subregional networks of regulatory authorities, as appropriate, including strengthening areas of regulation of health products that are the least developed, such as regulation of medical devices, including diagnostics;

¹ And, where applicable, regional economic integration organizations.

(54) to promote the greater participation of Member States in existing international and regional initiatives for collaboration, ~~harmonization~~ and **COOPERATION** ~~convergence~~ in accordance with WHO principles and guidelines;

(65) ~~{to strengthen the integration and coherence among WHO's prequalification programmes, as an aid~~ **INCLUDING THEIR INTEGRATION AND COHERENCE, TAKING INTO ACCOUNT THE NEEDS AND CAPACITIES OF NATIONAL AND REGIONAL REGULATORY SYSTEMS to assuring safe ASSIST IN ENSURING A supply of quality, SAFE, EFFICACIOUS AND AFFORDABLE medical products, engaging with Member States in the further refinement and improvement of the global prequalification model, while in parallel supporting the development of functional;**

(7) **TO SUPPORT BUILDING UP EFFECTIVE national and regional regulatory bodies and networks;** ~~leading to more global participation in the global prequalification programme;~~

(86) to increase support for and recognition of the significant role of the International Conference of Drug Regulatory Authorities in promoting the exchange of information and collaborative approaches among drug regulatory authorities, and as a resource to guide and facilitate further development of, ~~and regulatory COOPERATION AND COHERENCE; harmonization and convergence among, these authorities;~~

(97) to raise awareness of the importance of effective regulatory systems within the health system context;

(108) to increase support and guidance for strengthening the capacity to regulate increasingly complex biological products with the focus on biotherapeutic products, blood products and associated in vitro diagnostics, and, where appropriate, on new medicines for human use based on gene therapy, somatic-cell therapy and tissue engineering;

(11) TO ENSURE THAT ANY ACTIVITY CARRIED OUT UNDER THIS RESOLUTION DOES NOT DUPLICATE OR CIRCUMVENT THE WORK PLAN AND MANDATE OF THE MEMBER STATES MECHANISM ON SSFFC MEDICAL PRODUCTS;

(129) to report to the Seventieth and Seventy-second World Health Assemblies, through the Executive Board, on progress in the implementation of this resolution.

He also drew attention to a revised version of the draft resolution contained in resolution EB134.R19, incorporating amendments proposed by various delegations, which read:

The Sixty-seventh World Health Assembly,

PP1 Recalling the WHO Constitution, which affirms 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 Noting with particular concern that for millions of people, the right to the enjoyment of the highest attainable standard of physical and mental health, including access to medicines, remains a distant goal, that especially for children and those living in poverty, the likelihood of achieving this goal is becoming increasingly remote, that millions of people are driven below the poverty line each year because of catastrophic out-of-pocket payments for health care, and that excessive out-of-pocket payments can discourage the impoverished from seeking or continuing care;

PP3 Recalling resolution WHA55.14 on ensuring accessibility of essential medicines, which recognizes "the responsibility of Member States to support solid scientific evidence, excluding any biased information or external pressures that may be detrimental to public health";

PP4 Further recalling that resolution WHA55.14 urged Member States, inter alia, “to reaffirm their commitment to increasing access to medicines, and to translate such commitment into specific regulation within countries, especially enactment of national drug policies and establishment of lists of essential medicines based on evidence and with reference to WHO’s model list into actions designed to promote policy for, access to, and quality and rational use of, medicines within national health systems”;

PP5 Considering that one of the objectives of pharmaceutical regulation is the assurance of the quality, safety and efficacy of pharmaceutical products through the regulatory processes of authorization, vigilance and monitoring;

PP6 Considering also that national pharmaceutical regulation should contribute to the performance and sustainability of health systems and the general welfare of society;

PP7 Considering that an update of the norms and standards applicable to medicines is required in the light of advances made in biotechnology, and the new generation of medicines introduced as a result, in order to ensure the entry into the market of medicines that are affordable, safe, efficacious, of quality and accessible in a timely and adequate fashion;

PP8 Recognizing that the use of such medicines has a positive impact on morbidity and mortality rates and that, while there are multiple barriers to access, their high cost affects the sustainability of health systems and could in many cases affect access to them;

~~PP9 Noting the WHO Expert Committee on Biological Standardization guidelines of 2009 on evaluation of similar biotherapeutic products and that the placing on the market of these types of products is expected to significantly increase;}~~

PP9 Noting the importance, and use as appropriate, of WHO Guidelines on evaluation of similar biotherapeutic products (2009) by the Expert Committee on Biological Standardization, and recognizing the need to update them, particularly in terms of technological advances and characterization in order to promote more efficient regulatory frameworks from a public health perspective that ensure the efficacy, quality and safety of these products at the national and regional level;

PP10 Conscious that similar biotherapeutic products could be more affordable and offer better access to treatments of biological origin, while ensuring quality, safety and efficacy,

(OP.1) URGES Member States:¹

(OP1.1) to develop or strengthen, as appropriate, national regulatory assessment and authorization frameworks, with a view to meeting the public health needs for biotherapeutic products, ~~and in particular including~~ similar biotherapeutic products;

~~{(1)bis — to ensure that a solid, scientifically-based regulatory review process for reviewing, approving, and monitoring reference biotherapeutic products has been conducted before embarking on the review and approval of similar biotherapeutic products;}~~

(OP1.2) **To develop the necessary scientific expertise to facilitate development of solid, scientifically-based regulatory frameworks that would promote access to products that are affordable, safe, efficacious, of quality, taking note of the relevant WHO Guidelines which may be adapted to the national context and capacity;**

(OP.2) REQUESTS the Director-General:

(OP2.1) to support Member States in strengthening their capacity in the area of the health regulation of biotherapeutic products, ~~and in particular including~~ similar biotherapeutic products;

¹ And, where applicable, regional economic integration organizations.

(OP2.2) to support, as appropriate, the development of national regulatory frameworks that promote access to quality, safe, efficacious and affordable biotherapeutic products, ~~and in particular including~~ similar biotherapeutic products;

(OP2.3) to encourage and promote cooperation and exchange of information, as appropriate, among Member States in relation to biotherapeutic products, ~~and in particular including~~ similar biotherapeutic products;

(OP2.4) to convene the WHO Expert Committee on Biological Standardization to update the 2009 guidelines, taking into account the technological advances for the characterization of biotherapeutic products and considering national regulatory needs and capacities and to report on the update to the Executive Board;

(OP2.5) to report to the WHA69 through the Executive Board on the progress with the implementation of this resolution.

The financial and administrative implications for the Secretariat remained unchanged.

Dr OKABAYASHI (Japan) said that the progress of globalization meant that medical products and equipment were produced transnationally and could not be controlled entirely within one country. Collaboration between regulatory agencies was therefore crucial to improving the regulatory capacity of each system. Japan highly appreciated WHO's engagement in facilitating links between developed and developing countries, and would continue to support the central role played by WHO in strengthening regulatory systems through the existing regulatory harmonization frameworks.

Ms SITI AIDA ABDULLAH (Malaysia) said that her Government supported and would implement the initiative for good governance in the pharmaceutical sector; it also supported WHO's proposal to design core curricula for the training of regulators and that national drug regulatory authorities should form networks to share information and avoid duplication of work. In addition to support from WHO, reports from and training by established national regulatory authorities would provide useful guidance for countries lacking technical expertise, especially in the area of biotherapeutics.

She supported the move towards convergence of regulatory requirements and the development of a comprehensive assessment tool that could be adapted for use in different regulatory environments. She understood the limitations on expanding the prequalification programme to include all products of importance to public health and agreed that other modalities should be developed for use in countries with limited regulatory capacity and without access to products prequalified by WHO.

Dr MAKUBALO (South Africa) said that, owing to competing needs for resources, approaches such as strategic partnerships, prioritization, appropriate information technology infrastructure and capacity-building should be explored. She therefore supported the establishment and expansion of regional and international networks to achieve the Organization's regulatory goals, as well as the strengthening of mechanisms for information-sharing and the promotion of good regulatory practices. She supported the draft resolutions.

Ms VALLINI (Brazil) said that many challenges to regulatory systems still remained, such as effective reporting on monitoring and surveillance, streamlining communication and ensuring effective and timely responses. With regard to the revised version of the draft resolution contained in resolution EB134.R17, she proposed deleting the words "guide and" in subparagraph 2(8), as she did not believe that the mandate of the International Conference of Drug Regulatory Authorities included a guidance function. Given the importance of the supply chain for biotherapeutic products, she supported the draft resolution contained in resolution EB134.R19.

Ms HE Li (China) said that the Government of China actively supported cooperation between autonomous national regulatory authorities and the convergence of regulatory norms and technical standards under WHO's auspices. National regulatory authorities should decide, in the light of national conditions, whether to rely on regulatory networks and international regulatory guidelines. Similarly, governments should decide whether to harmonize their rules and regulations and should determine their own goals, pathways and processes for technical harmonization and convergence. In particular, when designing the assessment tool, the opinions of all countries, particularly developing countries, should be taken into account. She welcomed the revised version of the draft resolution contained in resolution EB134.R19.

Mr COTTERELL (Australia) supported the revised versions of the draft resolutions contained in resolutions EB134.R19 and EB134.R17, as a sponsor in the case of the latter. Noting that all references to regulatory convergence and harmonization had been removed from the revised version of the draft resolution contained in resolution EB134.R17, he wished it to be placed on record that those concepts were important to his country, which, like many other Member States, relied on trade for access to many essential medicines. Major differences and inconsistencies in regulatory systems among countries that traded in medicines contributed to delays in access to medicines and decreased the affordability of essential medicines for patients. He wished to see further discussion of those issues by the governing bodies in the future.

Mr PIPPO (Argentina) welcomed the measures taken by the Secretariat to support Member States in strengthening their regulatory systems. Those systems should give priority to public health over commercial interests. The complex nature of biotechnology required regulatory norms and standards to be updated. However, the high cost of medicines could compromise health system sustainability and thus constitute a barrier to access. He endorsed the view expressed by health ministers of the Union of South American Nations that similar biotherapeutic products could be more affordable and accessible, and promote access to medicines, and therefore to health, including universal health coverage. He commended the draft resolution contained in resolution EB134.R19 for adoption by the Sixty-seventh World Health Assembly.

Dr VALVERDE (Panama) welcomed the draft resolution contained in resolution EB134.R19. Coordination and coherence between policies to protect public health and those on the financial stability of health systems posed a major challenge for governments. The WHO guidelines on evaluation of similar biotherapeutic products, drawn up by the Expert Committee on Biological Standardization in 2009, should be updated in the light of scientific developments and in line with the objectives of the draft resolution, of which she asked for her country's name to be included as a sponsor.

Mrs SITANUN POOLPOLSUB (Thailand) said that the two draft resolutions under discussion were milestones in tackling the matter and, with the amendments proposed by the delegations of the United States of America, Argentina and other sponsors, embodied a balanced and comprehensive approach, which she strongly supported.

Dr DAKULALA (Papua New Guinea) supported the revised draft resolutions. Despite the lack of a national regulatory authority, guidance systems were in place in his country and a workforce plan had been launched to train regulatory specialists. Support from WHO and its partners for the development of modular core curricula would be welcome.

The Member State Mechanism on substandard/spurious/falsely-labelled/falsified/counterfeit (SSFFC) medical products would make an important contribution to the overall strengthening of regulatory systems. He commended WHO's progress towards validating a single, comprehensive and up-to-date global assessment tool that could be adjusted to the needs of regulators in different countries and settings.

Mr JAIN (India) said that, as a member of the Member State Mechanism on SSFFC medical products, his country had argued strongly for the strengthening of national regulatory authorities and quality control laboratories. Nonetheless, he had concerns about the Secretariat's report (document A67/32) and the revised draft resolution contained in resolution EB134.R17. The report focused on regulatory convergence and harmonization, alongside assessment of regulatory systems and support for WHO's prequalification programme. National regulatory systems had to cater to varying local needs, and as a result, global regulatory harmonization had not been achieved. WHO should therefore publish guidelines on strengthening regulatory systems, which Member States could voluntarily adopt and obtain the necessary support from the Secretariat to implement.

Endorsement of the need to strengthen individual countries' regulatory systems should not be linked to support for WHO's prequalification programme. Similarly, decisions on whether to participate in the regional and international initiatives referred to in the revised draft resolution contained in resolution EB134.R17 should be left to the judgment of each Member State and should be independent of support for regulatory system strengthening. Furthermore, there should be no duplication of efforts with the Member State Mechanism on SSFFC medical products.

On the understanding that support for regulatory system strengthening would not be linked to support for WHO's prequalification programme and that the development of norms, standards or guidelines would be free from conflicts of interest and would exclude influence from any industry-driven initiative, he supported both the revised draft resolutions.

Mrs NAARENDORP (Suriname), speaking on behalf of the Union of South American Nations, said that regulations on medical products should be robust and efficient, not only in their design but also in terms of the structure of the institutions responsible for surveillance and enforcement. A recent report of the Pan-American Network for Drug Regulatory Harmonization had concluded that the complexity associated with developments in biotechnology required adequate regulations and standards. At a meeting in her country in March 2014, health ministers of the Union of South American Nations had issued a declaration on the balance that must exist between access to similar biotherapeutic products and guarantees of safety, quality and efficacy. The process of updating national standards and regulatory requirements should be immune to pressures exerted by private interests, should take account of considerations of equity and social welfare, and should be based on scientific evidence.

Ms Li-Ying LAI (Chinese Taipei) said that Chinese Taipei was committed to providing consumer protection by strengthening regulations, building a comprehensive monitoring system and promoting risk assessment. Chinese Taipei was ready to share pharmaceutical information and cooperate with other regulatory and health authorities, regionally and globally, to build a better future for public health.

Dr PETRICCIANI (International Alliance for Biological Standardization), speaking at the invitation of the CHAIRMAN, said that complex new biological and other advanced products presented challenges to all national regulatory agencies, especially those in less developed countries, and it was clear that those agencies needed more support. Harmonization across regulatory authorities was critically important. Biological standardization was needed more than ever, and WHO must have the resources to undertake that task.

Quality assurance should be an integral part of the manufacturing system. All parties should recognize their responsibilities and the implications of their actions; for example, reducing investment in quality to reduce cost was counterproductive, as were redundant regulatory processes that hampered product development and improvement. He strongly supported the activities of WHO in the field of regulatory system strengthening, and the role it could play in facilitating regulatory harmonization and convergence.

Ms BERNAT (International Federation of Pharmaceutical Manufacturers and Associations), speaking at the invitation of the CHAIRMAN, said that science-based regulatory standards for medicines were essential, particularly given the complex nature of biotherapeutic products. Similar biotherapeutic products should be regulated via pathways that were distinct from those traditionally applied to generic medicines. Uniform regulatory requirements, following WHO principles, should be developed to ensure that all biotherapeutic medicines were safe and efficacious.

Ms HILL (MSF International), speaking at the invitation of the CHAIRMAN, said that WHO and its prequalification programme played a crucial role by strengthening national regulatory agencies' capacity and providing technical support to regional regulatory harmonization initiatives. Technical support to establish proper pharmaceutical policies, develop adequate supply channels and implement policies on sustainable pricing and rational medicine use was also valuable. It was critically important that Member States fund all key activities of the Department and that the Department concern itself with the priority health needs of Member States, rather than an agenda set by voluntary donors. Member States should introduce predictable, long-term core funding for the Secretariat so that it could enhance the support given to national drug regulatory agencies and regional agencies under development; expand the portfolio of the prequalification programme; enhance technical support at country level; and set norms and standards for global medicines regulation.

Mr GOPAKUMAR (Medicus Mundi International – International Organisation for Cooperation in Health Care), speaking at the invitation of the CHAIRMAN, said that he was concerned by WHO's participation in the International Conference on Harmonisation of Technical Requirements for Registration of Pharmaceuticals for Human Use. The International Conference compromised the neutrality of the standard-setting process and sought to raise industry standards for medicine manufacturing worldwide, despite the fact that, beyond a certain point, higher standards did not improve medicine quality or public health outcomes, but rather added to costs and acted as a barrier to the introduction of generics in low- and middle-income countries. He urged Member States to call for WHO's disengagement from the International Conference and for its exclusion from WHO expert committee meetings. A global mechanism was needed, under the aegis of WHO, to monitor all ethical issues regarding clinical trials, especially in low- and middle-income countries.

An increasing number of the drugs being developed and sold were biotherapeutic products. Accessibility and affordability should be key considerations in standard-setting, so that the market entry of low-cost similar biotherapeutic products was not restricted. WHO should build its own capacity to provide guidance on the regulation of biotherapeutic and similar biotherapeutic products, including support for scaling up the use and local production of similar biotherapeutic products in low- and middle-income countries.

The CHAIRMAN took it that the Committee wished to suspend discussion of the item in order to allow the delegate of the Syrian Arab Republic to respond to the comments of Member States on the proposed Syrian amendment to the revised version of the draft resolution contained in resolution EB134.R16, under agenda item 15.4.

It was so agreed.

(For resumption of the discussion, see page 319.)

Access to essential medicines: Item 15.4 of the Agenda (Documents A67/30 and EB134/2014/REC/1, resolution EB134.R16) (resumed)

The CHAIRMAN noted that the delegation of India had revised its amendment to subparagraph (OP1.2) of the revised version of the draft resolution contained in resolution EB134.R16 to read: "to

improve national policies for selection of essential medicines and other medicines critical to public health systems,”.

Dr ALABOUD (Syrian Arab Republic) emphasized the importance of the issue of sanctions against medical products for patients in affected countries. Noting the need for the Health Assembly’s work to be informed by consensus and further noting that the issue was a controversial one, and that the Health Assembly had reached the last day of its proceedings, he was willing to withdraw the proposed amendment to the draft resolution contained in resolution EB134.R16 but hoped to be able to raise the issue again at a later stage.

Mr LEWIS (Canada) proposed that, in view of the constitutional division of powers in his country, in subparagraph (OP1.1) the phrase “comprehensive national medicine policies” should be expanded to read “comprehensive national medicine policies, as appropriate”.

Ms KEKEMPANOU (Greece), speaking on behalf of the European Union, proposed the insertion of the word “their” in the revised amendment to subparagraph (OP1.2) proposed by the delegate of India, so that the first part of the subparagraph would read: “to improve national policies for selection of essential medicines and other medicines critical to their public health systems,”.

Mr PUSP (India) accepted the proposal made by the delegate of Greece.

Ms BURRIS (United States of America) asked what the Secretariat understood by the term “critical” in the context of a resolution dealing with access to essential medicines.

Dr KIENY (Assistant Director-General) said that there was no definition of the term “critical medicines”. She suggested that any Member State that wished to add a medicine that it deemed critical for its population to its national essential medicines list was free to do so, even if the item did not feature on the WHO Model List of Essential Medicines.

Dr REN Minghui (China) said that the meaning of critical medicines, as compared to essential medicines, was unclear.

Mr PUSP (India) said that he wished to maintain the proposed amendment to subparagraph (OP1.2), including the wording proposed by the delegate of Greece. The Secretariat had explained that lists of essential medicines might not include other medicines that were critical for national health systems and priorities.

Dr NITHIMA SUMPRADIT (Thailand), noting that the second preambular paragraph referred to WHO’s definition of essential medicines as encompassing medicines that satisfied the priority health care needs of the population, expressed concern that the use of the term “critical” in the draft resolution implied that the term would need to be used alongside every mention of essential medicines. She believed that “essential medicines” was a comprehensive concept that covered all medicines critical to public health.

The CHAIRMAN, noting that more time was needed to reach consensus on the draft resolution, took it that the Committee wished to suspend discussion of the item.

It was so agreed.

(For resumption of the discussion, see page 324.)

Regulatory system strengthening: Item 15.6 of the Agenda (Documents A67/32 and EB134/2014/REC/1, resolutions EB134.R17 and EB134.R19) (resumed)

Dr KIENY (Assistant Director-General) welcomed speakers' appreciation of and comments on the Secretariat's report. Since a large proportion of the health budget in low- and middle-income countries was spent on medicines and health technologies, governments needed to justify that investment and required strong national regulatory authorities to ensure that the manufacture, distribution and use of medical products were regulated effectively. The Secretariat played an important role globally in medicines regulation, including through the establishment of norms and standards, support for regulatory capacity-building and the strengthening of safety monitoring programmes and international collaboration. The quality, safety and efficacy of selected priority essential medicines, diagnostics and vaccines was ensured through WHO's prequalification programme, and the Secretariat appreciated the need to enhance and progressively move prequalification to networks of regulatory agencies. The Secretariat also welcomed the increasing number of regional collaboration initiatives of many regulatory authorities among themselves and with WHO.

Many countries lacked the capacity to regulate biotherapeutic products appropriately because of the complexity of the task. Moreover, their frequently high cost limited their accessibility to patients, particularly in developing countries. The licensing pathway for new similar biotherapeutic products was contingent partly on safety and efficacy information obtained in respect of the originator products. The term "biosimilarity" represented a new regulatory concept, and the new regulatory approaches were evolving and dynamic; it was therefore an opportune moment for the Health Assembly to highlight the need for both Member States and the Secretariat to strengthen their activities in that area. A two-day conference on access to biotherapeutic products would take place before the next International Conference of Drug Regulatory Authorities to be held in August 2014 with the support of the Government of Brazil.

The Secretariat would continue to conduct its norm- and standard-setting processes independently of any undue influence and with careful attention to avoiding conflicts of interest. Support for strengthening regulatory systems would continue in all countries that so requested, including those without prequalified products. She confirmed that additional financial resources were very much needed for WHO's work in the area of medicines.

The CHAIRMAN asked the Secretary to read out the proposed further amendment to the revised draft resolution contained in resolution EB134.R17.

Dr ONDARI (Secretary) said that the amendment proposed by the delegate of Brazil was to delete the words "guide and" in subparagraph 2(8).

The draft resolution, as amended, was approved.¹

The CHAIRMAN asked the Secretary to read out the proposed further amendment to the revised draft resolution contained in resolution EB134.R19.

Dr ONDARI (Secretary) said that the delegate of Argentina had proposed the reinstatement of subparagraph 1(3) with slightly amended wording, to read: "to work to ensure that the introduction of new national regulations, where appropriate, does not constitute a barrier to access to quality, safe, efficacious and affordable biotherapeutic products, including similar biotherapeutic products;"

The draft resolution, as amended, was approved.²

¹ Transmitted to the Health Assembly in the Committee's fourth report and adopted as resolution WHA67.20.

² Transmitted to the Health Assembly in the Committee's fourth report and adopted as resolution WHA67.21.

Ms VALLINI (Brazil) asked for her country to be included as a sponsor of both the draft resolutions that had just been approved.

Health intervention and technology assessment in support of universal health coverage: Item 15.7 of the Agenda (Documents A67/33 and EB134/2014/REC/1, resolution EB134.R14)

The CHAIRMAN asked the Secretary to read out proposed amendments to the financial and administrative implications for the Secretariat of the draft resolution recommended by the Executive Board in resolution EB134.R14, should it be adopted, which were contained in Annex 5 to document EB134/2014/REC/1.

Dr ONDARI (Secretary) said that, under section 3(b) on the cost for the biennium 2014–2015, the Secretariat had confirmed that the estimated cost for the biennium was included in the approved Programme budget 2014–2015. Under section 3(c) on staffing implications, the following should replace the current text: “No, recruitment will take place against approved positions that are included in the approved Programme budget.”

Mr AL ATAWI (Bahrain) said that the current economic situation in Bahrain posed numerous challenges with respect to the quality and efficacy of health services. Health coverage was available to all citizens, but investment was needed in health technologies, backed by national strategies for their deployment, together with relevant standards and guidelines. The draft resolution would contribute to speeding up decision-making processes and enhancing the effectiveness of health care and health coverage.

Ms ALVARADO SALAMANCA (Peru) said that the content of the draft resolution was in line with the Andean Community’s health technology assessment policy, signed by the health ministers of the Plurinational State of Bolivia, Chile, Colombia, Ecuador, the Bolivarian Republic of Venezuela and her own country. She commended WHO’s continued role in promoting health intervention and technology assessment in support of countries’ efforts to move towards universal health coverage. She supported the draft resolution.

Dr DUSHIME (Rwanda), speaking on behalf of the Member States of the African Region, said that, given their limited resources, African countries needed to prioritize and choose health technologies wisely. Any support with regard to the rational use and allocation of resources was welcome. Health technology assessment had proved to be a powerful paradigm for the institutionalization of evidence-based decision-making by health policy-makers. It offered a cost-effective tool to assist the priority-setting process. To ensure sustainability, open-source solutions and good business practices should be promoted. African countries needed to adapt global knowledge, support transparent decision-making and promote health equity for an effective global health system. He supported the draft resolution.

Dr AMMAR (Lebanon) said that countries with limited resources faced challenges in conducting health technology assessment. It should be institutionalized within national regulatory systems, and health technology management capacity should be developed at the level of health care delivery. An independent agency would be best placed to monitor, evaluate and analyse health technologies and interventions, paying due attention to potential conflicts of interest. WHO’s technical support was needed for capacity-building, including establishing such agencies and enhancing the regulatory capabilities of health ministries. WHO should also strengthen its normative functions in the areas of standard-setting and prequalification, and support countries in enhancing access to cost-effective new technologies. He supported the draft resolution.

Dr GUTIERREZ (Philippines) supported the draft resolution. Rising costs and expectations meant that institutional and technical capacity for health technology assessment needed constant development to meet the need for universal health coverage. His country had used health technology assessment to develop benefit packages for social health insurance, with the aim of ensuring the cost-effective use of resources and the high impact of health technologies. His country was a member of HTAsiaLink, a network supporting collaboration between agencies in Asia that aimed to advance health technology assessment practice and learning in the region. Such collaboration would be key to strengthening the position of countries such as his own that were struggling to manage limited health resources and increasing population needs.

Dr SHAHANIZAN MOHD ZIN (Malaysia) said that, as a sponsor of the draft resolution, her country recognized the importance of health technology assessment in generating evidence to inform the prioritization, selection, introduction, distribution and management of interventions for all aspects of health. Countries where health technology assessment was not yet part of the health financing system nevertheless faced challenges in implementation. Given that health technology assessment was a resource-intensive process, she urged WHO to take the lead in optimizing resources through shared databases and by providing expertise to support Member States in strengthening their capacities.

Dr KARADAYI (Turkey), noting the discrepancies in the terminology used in the field of health technology at national and global levels, said that WHO should play a leading role in resolving terminology issues by building global consensus and in collaboration with international and regional working groups. He supported the draft resolution.

Mr WEIBUST (Norway) supported the proposals in the draft resolution, which would encourage the scaling up of national health technology assessment capacities. Regional and international strategies for sharing best practices were a welcome means of avoiding duplication of efforts and thereby contributing to the rational use of resources. Proposals to integrate the concepts and principles of health technology assessment into existing WHO strategies would enhance the Secretariat's ability to support Member States.

Dr KANJANA CHUNTHAI (Thailand) supported the draft resolution. Capacity to carry out research into health technology assessment and use its findings in priority-setting and policy development was lacking in most developing countries. With reference to the global guidance in subparagraph 2(4) of the draft resolution, the Secretariat could help mobilize expertise and other resources to facilitate the preparation of methodological and management guidelines for resource-constrained countries, which should include an internationally agreed code of conduct for researchers, policy-makers and stakeholders involved in health technology assessments and associated policy decisions. Her country strongly supported WHO in providing technical support to international entities in order to ensure the rational and efficient allocation of resources for health. She had appreciated the convening by WHO of a technical briefing on 23 May 2014, with contributions from the Secretariat, decision-makers, experts and practitioners, at which Member States had improved their understanding of the role of health intervention and technology assessment in support of universal health coverage.

Mr SILLO (United Republic of Tanzania) said that in striving to achieve universal health coverage, his country had introduced a number of measures, including an eHealth strategy, but needed health intervention and technology assessment to inform decision-making and priority-setting, since not all interventions and technologies were cost-effective. WHO should collaborate with relevant institutions to establish a hub in the African Region and ensure that capacities were evenly distributed in all regions. He strongly supported the Secretariat's proposal concerning the need to build Member States' human resource capacity, increase the use of health technology assessment to inform public policy and establish an institutional framework for decision-making based on health technology assessment. He supported the draft resolution.

Ms CHEN Ningshan (China) said that China was strengthening advocacy of health technology and intervention assessment and enhancing cooperation among international organizations. Member States' experience of establishing health intervention and technology assessment systems and institutions should be included in the Secretariat's report, in order to facilitate government decision-making. The report should also encourage Member States to promote institutional safeguards for health intervention and technology assessment through laws and regulations. The Secretariat should strengthen its financial and technical support for developing countries, in order to help them conduct health intervention and technology assessments and improve their assessment capacity.

She supported the draft resolution in principle but wished to propose two amendments. At the beginning of subparagraph 1(1), the words "to consider establishing national systems of health intervention and technology assessment and" should be inserted before the words "to encourage". A new subparagraph 1(1)bis should also be inserted, which would read: "to strengthen the link between health technology assessment (HTA) and health technology regulation (HTR)".

Dr WIDIYARTI (Indonesia) said that the increasing number of patients with noncommunicable diseases generated higher treatment costs and called for the use of advanced technology for diagnosis and treatment. Meeting that need required the selection, purchase and maintenance of appropriate health technology and ongoing personnel training. Decision-making on those issues must therefore be based on skilful cost-benefit analyses. Clearly, health intervention and technology assessment was needed in order to enhance the quality, efficacy and safety of health services. Among other measures, her country was establishing a team to identify and recommend evidence-based policies that would support the patient-friendly, effective and efficient operation of the national social health insurance scheme. She supported the draft resolution.

Ms R. RASHEED (Maldives), speaking on behalf of the Member States of the South-East Asia Region, noted that a resolution on health intervention and technology assessment in support of universal health coverage had been adopted by the Regional Committee for South-East Asia in September 2013, and the draft resolution under consideration had been initiated by that Region. It was important to take a broad view of health interventions and to pay due attention to reducing inequities and achieving efficiency gains. It was also essential to build sustainable country capacities, in order to strengthen evidence-based decision- and policy-making. Member States and regional offices needed to network more closely to share knowledge and expertise in relation to health intervention and technology assessments.

Dr ARAKI (Japan) said that it was important to distribute limited resources appropriately in the effort to achieve universal health coverage. Assessments had been conducted in his country of the safety and efficacy of health technology, although criteria had not yet been established regarding cost-effectiveness. Countries attempting to establish health insurance systems should introduce health technology assessments for economic reasons and for the sake of transparency. Cost considerations should be included in the analysis of the extent to which health technology could be safely and effectively introduced, taking into account the systems and supply structure in each country, as well as clinical, ethical and social conditions. Networks based on WHO regional offices could facilitate the task of health technology assessment for countries that found it difficult to build their own capacity. He expressed support for the draft resolution.

Mr KIM Young-hak (Republic of Korea) said that in his country data produced by an agency of the health ministry were used to determine the health insurance benefits of new health technologies. In addition, a health care expansion plan was being implemented, based on health technology assessment. The Republic of Korea would join WHO's efforts to expand cooperation among health technology assessment organizations at country, regional and global levels, as suggested at the 10th meeting of Health Technology Assessment international in Seoul in 2013. He therefore strongly supported the draft resolution.

Mr PIPPO (Argentina) commended the Secretariat's promotion of and support for the use of health intervention and technology assessments by Member States. Such assessments were an important tool for decision-making and resource allocation in an environment characterized by the quickening pace of market entry for expensive new health products that frequently offered few clinical benefits. The results of those assessments should be part of a wide range of factors that informed decision-making, such as assessments by ethics committees and comprehensive analysis of the health, economic, social and political implications of any decision. Cost-effectiveness criteria were an important element in resource allocation processes but should be subordinate to criteria of public health and general well-being. Assessments should always be carried out in the same national context where the decision was to be taken, and original data should be nationally representative. Each Member State had a role to play in defining its strategy for the inclusion of technologies in its health delivery system. The Secretariat should support Member States by continuing to share best practices and experience in that regard and training human resources. He supported the draft resolution.

Dr GYANSA-LUTTERODT (Ghana) said that in implementing a social health insurance scheme, her country viewed health intervention and technology assessment as a strategic methodology to reduce waste and leverage efficiency in its health system. It sought effective partnerships and collaboration with other countries possessing experience in that area, in order to build the necessary platforms for knowledge-sharing. Evidence-based clinical evaluations were important, but economic evaluations could add value and were strategic for achieving universal health coverage. WHO should support countries by brokering knowledge and building capacity. She urged Member States to adopt the draft resolution.

Dr TRAN THI GIANG HUONG (Viet Nam) proposed amendments to the draft resolution. In subparagraph 1(1), the word "medicines" should be replaced by the phrase "reimbursement and pricing of medicines". In subparagraph 1(5), the word "institutional" should be inserted between "national strategic plans concerning" and "capacity-building". The last part of subparagraph 1(6) should be amended to read: "considering technical support and strengthening regional and international networking for information exchange, joint assessment and adaptation of findings from other Member States and WHO on health intervention and technology assessment;". The Secretariat was urged to provide technical support for the development of health technology assessment capacity at country level.

Mr McIFF (United States of America) said that the appropriate use of safe, high-quality health technologies could make a decisive contribution to global health. Health technology assessments could be invaluable to the sustainability of health systems. Each country should make its own decisions about how to improve the quality of care and manage costs. Evidence-based decision-making in health care was essential.

Although he would have preferred the draft resolution to be approved without amendments, he could support the first amendment proposed by the delegate of China for the insertion of new text at the beginning of subparagraph 1(1). The second amendment, however, for the addition of a new subparagraph 1(1)bis, was not acceptable.

Mr SOSSOU (Benin) observed that African Member States, among others, faced a variety of challenges in their efforts to overcome the financial barriers to the achievement of universal health coverage. The existence of two sectors of economic activity, one formal, the other informal, complicated the establishment of mechanisms to collect financial contributions in support of universal coverage. The Secretariat should therefore provide technical support to Member States for the establishment of reliable mechanisms to collect contributions from the informal sector. With support from WHO and the Providing for Health (P4H) Social Health Protection Network, Benin had developed a national financing strategy for the achievement of universal health coverage.

Mr I-Ming PANG (Chinese Taipei) commended the strategy of using health intervention and technology assessment in support of universal health coverage. Since 2007, health technology assessment had made a substantial contribution to Chinese Taipei's universal health insurance system. Almost all important new medicines in Chinese Taipei had to undergo a health technology assessment before they could qualify for health insurance reimbursement. A recent major health reform had focused on the principles of accountability, equity, quality and efficiency, and an independent agency had been established to implement health technology assessment. Chinese Taipei would host the fourth HTAsiaLink annual conference in 2015 and looked forward to the participation of Member States.

Dr LAU (International Society of Radiology), speaking at the invitation of the CHAIRMAN, said that improved access to basic radiology and the achievement of more equitable and universal health coverage were community health priorities. Access to radiology depended on a combination of health professional capacities and the use of innovative and sustainable technologies. Improvements in universal health coverage involved all stakeholders in complementary roles. His organization was ready to assist WHO by facilitating the training of health professionals and advising on the selection of safe, affordable and appropriate technologies. He urged the Health Assembly to adopt a resolution along those lines.

Dr KIENY (Assistant Director-General) thanked delegates for their comments and said that the pursuit of equity, quality of care and efficiency was a major challenge for health systems and for achieving universal health coverage. The drive to achieve such coverage and to ensure the provision of affordable services to all populations heightened the need to choose interventions judiciously and to manage health technologies effectively. Health technology assessment was used to inform policy- and decision-making in health care, especially with regard to the allocation of limited resources. The Secretariat would undertake global mapping of current capacity, needs and opportunities for health technology assessment in Member States. It would also prioritize the advocacy and promotion of priority-setting approaches; dissemination of best practices and facilitation of experience-sharing among countries, including through the development of platforms for information exchanges; and capacity-building and networking. The Secretariat would also strengthen the use of health technology assessment in its own recommendations and guideline processes.

Ms CHEN Ningshan (China) said that her delegation had prepared a revised version of the amendment it had proposed earlier for the addition of a new subparagraph after subparagraph 1(1). The revised amendment read: "to strengthen the link between health technology assessment and regulation and management, as appropriate;".

Mr McIFF (United States of America) supported the revised amendment.

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

The draft resolution, as amended, was approved.¹

Access to essential medicines: Item 15.4 of the Agenda (Documents A67/30 and EB134/2014/REC/1, resolution EB134.R16) (resumed)

Dr NITHIMA SUMPRADIT (Thailand) said that informal consultations had led to agreement on new wording for the amendment proposed by the delegate of India to subparagraph (OP1.2) of the

¹ Transmitted to the Health Assembly in the Committee's fourth report and adopted as resolution WHA67.23.

revised version of the draft resolution. The first part of that subparagraph would now read: “to improve national policies for selection of essential medicines which should include medicines critical to their priority public health needs,”. The remainder of the subparagraph, beginning with the words “particularly by using”, would remain unchanged.

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

The draft resolution, as amended, was approved.¹

Follow-up of the Recife Political Declaration on Human Resources for Health: renewed commitments towards universal health coverage: Item 15.8 of the Agenda (Documents A67/34 and EB134/2014/REC/1, resolution EB134.R15)

Mr VON KESSEL (Switzerland) noted with satisfaction the reaffirmation, in the draft resolution contained in resolution EB134.R15, of the importance of the WHO Global Code of Practice on the International Recruitment of Health Personnel and the recognition of WHO’s leadership role in human resources for health. The institutional monitoring mechanisms to ensure its implementation were one of the main assets of the Code, although their potential had not yet been fully realized. He enquired about the next steps and the resources available to the Secretariat to ensure effective implementation of the Code and follow-up to the Third Global Forum on Human Resources for Health, in particular with a view to drafting the national reports due in 2015.

Dr VALVERDE (Panama) said that, in view of the need for human resources for health at the regional level, particularly in areas that were difficult to access, her country would implement its commitments under the Recife Political Declaration on Human Resources for Health in accordance with its national and subnational responsibilities, as part of its renewed commitment to universal health coverage. She supported the draft resolution and asked for her country to be included as a sponsor.

Dr JASUNDARA BANDARA (Sri Lanka) said that universal health coverage was a basic requirement for a country’s sustainable development, and a strong national workforce was needed to meet that requirement. Development of that workforce would be a long-term investment in attaining the highest possible level of health and well-being for the population and in economic development. His country remained committed to strengthening primary health care, and developments such as the increase in noncommunicable diseases and population ageing necessitated expansion of the workforce at the community level. Both developing and middle-income countries needed to invest substantially in training and then retaining such a workforce. Although the export of medical personnel had been a valuable source of income for many countries, they had come to realize that the drain of those skills had a serious impact on universal health coverage. Destination countries that benefited from the skills of those workers should therefore support source countries in scaling up their training of health personnel.

Dr SHAHANIZAN MOHD ZIN (Malaysia), welcoming the draft resolution, said that Member States’ commitment to the agenda for health workforce development at all levels would bring closer the shared vision adopted through the Kampala Declaration and Agenda for Global Action. She expressed support for the 10 measures for implementation set out in the Recife Political Declaration on Human Resources for Health, while noting the importance of promoting technical cooperation and capacity-building. Her country was preparing a master plan that would set the strategic directions for

¹ Transmitted to the Health Assembly in the Committee’s fourth report and adopted as resolution WHA67.22.

the development of human resources for health in the period 2016–2030. Malaysia had adopted the Recife Political Declaration on Human Resources for Health.

Dr NITHIMA SUMPRADIT (Thailand), speaking on behalf of the Member States of the South-East Asia Region, said that most of the countries in the Region, which contained both destination and source countries for health personnel migration, faced challenges in respect of workforce shortages, distribution, skill mix, production capacity, management, development and information systems. She noted with concern the inadequate implementation of the WHO Global Code of Practice on the International Recruitment of Health Personnel. The Region was nevertheless committed to strengthening the health workforce through training and the development of regional strategies.

The draft resolution, which she supported, could be improved by three amendments. A new preambular paragraph should be inserted between the third and fourth preambular paragraphs, to read: “Concerned that challenges, since the Kampala Declaration in 2008, in solving the shortages and maldistribution of appropriately trained and motivated health workers and the inadequate implementation of WHO Global Code of Practice on International Recruitment of Health Personnel, continue to hamper the effective functioning of health systems, hinder access, and achieve health-related Millennium Development Goals,”. The second preambular paragraph should be amended to read: “Recognizing the leadership role of WHO in human resources for health, and the mandate given in this regard by resolutions WHA63.16 on WHO Global Code of Practice on International Recruitment of Health Personnel, WHA66.23 on transformative health workforce education in support of universal health coverage, WHO’s global policy recommendations on increasing access to health workers in remote and rural areas through improved retention in 2010, and WHO’s guideline on transforming and scaling up health professional education and training in 2013;”. The following wording should be added at the end of paragraph 3: “and provide technical support to Member States to strengthen their health workforce and report the progress in implementing this resolution to the Seventieth World Health Assembly through the Executive Board”.

The meeting rose at 12:30.

SEVENTH MEETING

Saturday, 24 May 2014, at 14:45

Chairman: Dr M. ASADI-LARI (Islamic Republic of Iran)

1. **HEALTH SYSTEMS:** Item 15 of the Agenda (continued)

Follow-up of the Recife Political Declaration on Human Resources for Health: renewed commitments towards universal health coverage: Item 15.8 of the Agenda (Documents A67/34 and EB134/2014/REC/1, resolution EB134.R15) (continued)

Ms BALAS (Germany), welcoming the reaffirmed leadership role of WHO on the issue of human resources for health, said that human resources were an essential building block for strengthening health systems and were a crucial component of its programmes in partner countries, particularly in Africa and Asia. She encouraged Member States to implement the WHO Global Code of Practice on the International Recruitment of Health Personnel.

Dr GUTIERREZ (Philippines) said that universal health coverage would not be achieved without competent, skilled and committed health workers. High-level political commitment and solidarity were two elements that would help countries to respond effectively to human resources-related challenges. It was important to adopt a global and regional perspective on human resources for health and ensure that Member States had sufficient resources to allocate to the issue. As a country that produced a large number of highly committed and talented nurses, Philippines was keen to see universal recognition of the importance of implementing the WHO Global Code of Practice; there should also be wider opportunities for the establishment of networks to promote the best interests of the health workforce, which would ultimately contribute to better health care for patients.

Dr USHIO (Japan) said that it was important to maintain countries' interest in the issue: long-term support was crucial to the achievement of universal health coverage, and results were often not visible in the short term. Therefore the role of the Secretariat could not be underestimated, and it would be important to ensure that it had sufficient funding and human resources. In addition, it was to be hoped that more countries would make a commitment to support the Global Health Workforce Alliance, including through financial contributions. A new paragraph should be added to the draft resolution contained in resolution EB134.R15, which would read: "REQUESTS the Director-General to develop and submit a new global strategy for human resources for health for the consideration of the Sixty-ninth World Health Assembly."

Dr GONZÁLEZ FERNÁNDEZ (Cuba) said that the Recife Political Declaration was a crucial commitment, given that to achieve universal health coverage and ensure the equity, quality and efficacy of health systems it was vital to have sufficient health personnel; without universal health coverage, it would not be possible to ensure good health for all and achieve sustainable development. In order to address the shortage of doctors and contribute to universal health coverage, Cuba was training physicians and collaborating with developing countries; however, physicians working in countries other than the one in which they had been trained faced many challenges, particularly with regard to recognition of their qualifications. It was therefore important to revise the WHO Global Code of Practice; in resolution WHA63.16 the Sixty-third World Health Assembly had decided that the first review of the relevance and effectiveness of the Code would be made by the Sixty-eighth

World Health Assembly. To that end, the Secretariat should prepare a report and a draft resolution on the issue for consideration by the Executive Board at its 136th session. The preparation of that report was in line with the proposal made by the delegate of Japan; the two proposals could therefore be merged and included in the amendment to the draft resolution under consideration.

Ms CHEN Ningshan (China) expressed concern that although all Member States had made progress in strengthening the training of health personnel, countries in sub-Saharan Africa continued to suffer the most from a severe shortage of health-related human resources; that state of affairs posed a significant challenge to the achievement of the Millennium Development Goals and universal health coverage in those countries. Member States must honour their commitments in that area and integrate health-related human resource development activities into their national health development plans. The Secretariat should play a leading role in that regard through the organization of coordination and technical support; mobilization of the Global Health Workforce Alliance; and monitoring of health-related human resources. She supported the draft resolution.

Mr MENGUE ME ENGOUANG (Gabon), speaking on behalf of the Member States of the African Region, said that substantial progress had been made on the issue over the years, but that challenges remained as a result of poor management of health personnel. The African Region was focusing on training mid-level personnel in order to facilitate better sharing of tasks and thus improve the efficacy of health systems. It was also endeavouring to incorporate community health workers into that strategy, as those workers played a fundamental role in many countries. The brain drain experienced by many countries in the Region was a matter of concern, and destination countries should develop compensation mechanisms such as building up the capacity of local training facilities or payment of source countries' costs.

Many countries in the Region had already taken steps to achieve universal health coverage; those countries that had not yet done so should step up their efforts as soon as possible. A good human resources development plan combined with effective implementation of universal health coverage would be an appropriate response to the health needs of the continent's population.

Mr KLEIMAN (Brazil) said that many countries, regardless of socioeconomic status, faced the challenge of finding a balance between the supply of and demand for health professionals. In some cases, the gaps made it difficult to achieve the Millennium Development Goals and increase access to health care. The Recife Political Declaration proposed national and international activities to increase the number of health professionals and improve health-related training. With the support of PAHO, WHO and other partners, Brazil had introduced many measures on the subject, particularly with regard to expanding human resources in remote areas. A balanced distribution of human resources for health, enhancement of their professional status and high-quality training were all essential for universal health coverage, which should be both a national and a global goal.

Mr KIM Young-hak (Republic of Korea) said that his country had been the first in Asia to introduce clinical performance aspects into the medical licensing examination; it also planned to introduce a certification system to help improve the quality of its medical schools. With regard to health personnel, it was important to move away from focusing solely on clinical skills; more attention must be paid to improving the "social capacity" of physicians with regard to the physician-patient relationship and ethics, for instance. All countries were affected by imbalances in their health workforces, so it was vital to share best practices to help address the issue.

Mr KOLKER (United States of America), expressing appreciation for the efforts of WHO to reorganize and streamline its capacity and that of the Global Health Workforce Alliance, observed that although the WHO Global Code of Practice was reaffirmed in the Recife Political Declaration, there had been a poor response rate to the first survey on the Code. It was important that Member States, the

Secretariat and other stakeholders provided support to countries in addressing health workforce capacity and the role of civil society.

Mr MATUTE HERNANDEZ (Colombia) said that human resources often posed significant challenges, particularly in terms of discrepancies between supply and demand, the focus on single diseases rather than on prevention, imbalances in distribution and the impact of epidemiological transitions. As a result, efforts had had to be stepped up at national and global levels to develop, implement and monitor strategies and plans aimed at ensuring a sufficient and sustainable health workforce and improving information systems and training. It was important to foster cooperation schemes related to transferring skills and technology and strengthening institutional capacity.

Dr WIDIYARTI (Indonesia) strongly supported renewal of the global commitment to the development of human resources for health at global, regional, national and subnational levels. Indonesia was committed to continuing its efforts in that regard through appropriate planning, supported by a strong information system, training and education, and quality control. Close collaboration with relevant stakeholders was required, and the Secretariat should provide technical support to Member States where necessary. She expressed support for the draft resolution.

Dr OBEMBE (Nigeria) stressed the need to include training of the mid-level health workforce and community and village health workers, as well as task-shifting and task-sharing, in all efforts to strengthen and improve human resources for health.

Mrs NAARENDORP (Suriname), speaking on behalf of the Union of South American Nations, said that one of the main difficulties faced in taking global health action to promote the well-being of millions of people was the lack of health care professionals, which predominantly affected developing countries. It also had an impact on countries' ability to fulfil their international commitments as WHO Member States. Acknowledging the leadership of WHO on human resources for health, she invited the Health Assembly to assess the Recife Political Declaration and the follow-up action to be taken. In view of the negative impacts on health policies generated by a lack of human resources, increasing and improving human resources for health should be a global priority. Synergies should also be established between the issue and other important global health initiatives.

Mr PIPPO (Argentina) said that training and upgrading human resources for health should be promoted. Having qualified health personnel was a condition for achieving universal health coverage and ensuring full exercise of the right to health. International collaboration should be at the forefront of all efforts in that regard; the Recife Political Declaration was a good reflection of the options that countries should consider in order to make progress on the issue.

Mr SOSSOU (Benin) said that Member States, particularly those from the African Region, faced a number of difficulties. With regard to improving the quality and quantity of human resources, it was important to note that as a result of retirement, many countries would need to make substantial investments in recruiting sufficient personnel to enable health services to function. Nonetheless, a prudent ratio would have to be maintained between the total wage bill and overall government investment to comply with the macroeconomic requirements imposed. It would be difficult to reconcile that situation with the Recife Political Declaration. He fully supported the draft resolution.

Ms RUIZ VARGAS (Mexico), expressing support for the draft resolution, reaffirmed her country's commitment to mobilizing political will in order to act as a catalyst for activities in the area of human resources for health and respond to current needs.

Mr ŞEN (Turkey) said that his country had endeavoured to increase the number of health professionals and to address the poor distribution of health personnel in remote and underserved areas

through, inter alia, increasing the number of medical students and using contract-based recruitment models and a performance-based supplementary payment system. Those efforts had been fundamental for the achievement of universal health coverage in the country. Implementation of the WHO Global Code of Practice would require collaboration and exchanges of information between Member States, together with technical support from WHO. The important role of WHO as an enabler and facilitator should not be underestimated. In addition, development of human resources for health should be given due consideration in the deliberations on the post-2015 development agenda.

Dr Wui-Chiang LEE (Chinese Taipei) said that achieving universal health coverage but with a high patient volume and at relatively low cost meant that shortages in the health workforce were a significant challenge. The most marked shortages were of frontline nurses, critical care doctors, midwives, and paediatric surgeons in tertiary care facilities. To address the issues, measures such as financial incentives had been used. Health insurance reimbursement for critical care, emergency care, child delivery and paediatric care had been adjusted in order to increase the salaries of the relevant health workers. Efforts had also been made to improve the working environment of all health care workers and to enable large medical centres to support the human resource needs of hospitals in rural areas and offshore islands. Attention must be paid to the needs of hard-working health care workers while pursuing universal health coverage.

(For resumption of the discussion, see section 3 below.)

2. ORGANIZATION OF WORK

The CHAIRMAN announced that, following consultation between the President of the Health Assembly and the chairmen of Committees A and B, item 16.5 of the agenda (Antimicrobial drug resistance) would be transferred to Committee B.

It was so agreed.

3. HEALTH SYSTEMS: Item 15 of the Agenda (resumed)

Follow-up of the Recife Political Declaration on Human Resources for Health: renewed commitments towards universal health coverage: Item 15.8 of the Agenda (Documents A67/34 and EB134/2014/REC/1, resolution EB134.R15) (resumed)

Ms BELL (International Council of Nurses), speaking at the invitation of the CHAIRMAN, welcomed the focus on human resources for health, which was an essential component of universal health coverage. Equitable access to necessary health services required an adequate number of qualified nurses. The following actions in the Recife Political Declaration merited particular attention: capacity-building, development of regulatory frameworks, specialized training, strengthening of institutions and monitoring of health labour markets. Human resources for health should be fully included in the post-2015 development agenda. The Secretariat and Member States should ensure the active involvement of nurses and midwives in developing policies and implementing an agenda to maximize their potential and expertise, so as to achieve universal health coverage.

Ms FOSTER (World Confederation for Physical Therapy), speaking at the invitation of the CHAIRMAN, supported the draft resolution. There was a need to address the unequal access to health personnel at national and international levels. Rehabilitation professionals should be better reflected in

data on human resources for health, to ensure their optimum utilization, and included in policy-setting and health service planning. Using the services of a physical therapist as a first point of contact could increase patient satisfaction and reduce waiting times, costs and the prevalence of noncommunicable diseases. Member States should develop regulatory frameworks to ensure that patients had direct access to the most appropriate healthcare professional.

Mrs BAUMGARTEN (The Save the Children Fund), speaking at the invitation of the CHAIRMAN, called on Member States to adopt the draft resolution and fulfil the commitments to build health workforces that they had made in the Recife Political Declaration and at previous Health Assemblies. The Global Health Workforce Alliance and WHO should guide the development of a robust accountability mechanism to monitor the progress made towards agreed commitments. She welcomed efforts to develop a global strategy on human resources for health and the proposal that the Global Health Workforce Alliance should lead its development. Member States, the Secretariat and the Global Health Workforce Alliance should ensure that the health workforce was included as a target or indicator in the post-2015 development framework, so that the issue remained high on the agenda and progress was monitored at all levels.

Ms FOSTER (IntraHealth International Inc.), speaking at the invitation of the CHAIRMAN, urged stakeholders to work together, otherwise the existing global deficit of health care professionals would continue to grow. It was important to produce more health professionals, create stronger bridges from education to employment, maximize performance, motivate and retain workers, and reward commitment to high-quality care. Better access to health workers would enable progress to be made on all health issues, so the post-2015 development framework must include a health workforce target.

Mrs THOMAS (Medicus Mundi International – International Organisation for Cooperation in Health Care), speaking at the invitation of the CHAIRMAN, endorsed the importance attached to human resources for health. However, the Recife Political Declaration did not address the need for fiscal space to invest in those resources; the continuing brain drain and the need to compensate source countries; or the need to strengthen training institutions. The draft resolution should therefore be amended in order to ensure that donors, governments and multilateral actors devoted fiscal space to the development of a strong national health workforce; to promote equitable access to health care by investing in health workers at primary and community levels; to increase salaries, improve social protection and invest more in national training institutions; and to implement the WHO Global Code of Practice and legislate for compensation and redistribution mechanisms.

Mr ČECHLOVSKÝ (International Pharmaceutical Students' Federation), speaking at the invitation of the CHAIRMAN, said that it was important to include health care students and recent graduates in defining strategies and plans. High quality education was essential, and interprofessional education would facilitate the development of patient-centred collaborative practice approaches. The roles of health care professionals should be revised so as to maximize their practice potential. His organization was committed to bringing student and professional health care associations together to further develop interprofessional education and practice.

Mr SOUSA (International Federation of Medical Students' Associations), speaking at the invitation of the CHAIRMAN, welcomed the Recife Political Declaration but noted that it did not emphasize quality assurance in education. Independent, non-profit and academic-led accreditation agencies were essential in order to ensure the quality of higher education institutions for health care professionals. An increase in the number of health care workers would not lead to better care unless they had the proper training and skills. A lack of focus on the quality of education could worsen patient safety and increase the costs of health systems. Member States and the Secretariat should therefore support the inclusion of independent accreditation agencies in their policies.

Dr KIENY (Assistant Director-General) welcomed the support shown by Member States and civil society for the Recife Political Declaration. Universal health coverage required a broadened focus and perspective on the health workforce, including equitable geographic distribution and high-quality services. In that regard, the Secretariat would support Member States in seeking integrated solutions. She had noted the request by delegates that the Secretariat should develop a global strategy on human resources for health. Such a strategy would need to reflect the lessons learnt at national and regional levels over the previous decade and respond to the unprecedented societal demographic and epidemiological challenges being faced by all countries. The global health workforce community had initiated a consultation process, looking at how human resources planning models could better match supply and demand, how to expand transformative educational approaches, and how government stewardship and regulation could ensure better quality of care. WHO and the Global Health Workforce Alliance were collaborating with partners to identify best practice and innovative ideas. Unfortunately, the work proposed in the draft resolution and mandated by the WHO Global Code of Practice was currently only partially funded, but she hoped that situation would improve.

The Committee noted the report.

The CHAIRMAN invited the Committee to consider the draft resolution contained in resolution EB134.R15 and asked the Secretary to read out the amendments proposed.

Dr ONDARI (Secretary) said that three amendments to the draft resolution had been proposed by the delegate of Thailand. First, she had proposed adding the following words to the end of the second preambular paragraph: “, WHA66.23 on transforming health workforce education in support of universal health coverage, WHO’s global policy recommendations on increasing access to health workers in remote and rural areas through improved retention (2010) and WHO’s guidelines on transforming and scaling up health professionals’ education and training (2013)”.

Secondly, she had proposed adding a new preambular paragraph after the third preambular paragraph. With the permission of the delegation of Thailand, he had amended it slightly to read: “Concerned that challenges continue to hamper the effective functioning of health systems, hinder access and the achievement of health-related Millennium Development Goals, since the Kampala Declaration 2008, in solving the shortages and maldistribution of appropriately trained and motivated health workers and the inadequate implementation of WHO Global Code of Practice on the International Recruitment of Health Personnel”.

Thirdly, she had proposed adding the following words at the end of paragraph 3: “and provide technical support to Member States to strengthen their health workforce and report the progress in implementing this resolution to the Seventieth World Health Assembly through the Executive Board.”

Finally, the delegate of Japan had proposed introducing a new fourth paragraph, which would read: “REQUESTS the Director-General to develop and submit a new global strategy for human resources for health for consideration at the Sixty-ninth World Health Assembly”.

Ms DUSSEY-CAVASSINI (Switzerland) said that she was confused by the amendments that had been proposed and requested that they either be distributed in writing or be withdrawn, particularly as the text of the draft resolution had been previously agreed by the Executive Board.

Mr COTTERELL (Australia) supported the comments made by the delegate of Switzerland. With regard to the proposed amendments, he noted that the references to be included in the second preambular paragraph seemed to refer to resolutions adopted by the Health Assembly, so that amendment would be acceptable. The proposed new preambular paragraph referring to the Kampala Declaration, however, would need more investigation before it could be accepted. Finally, regarding the amendment proposed to paragraph 3 and the proposed new fourth paragraph, he asked the Secretariat whether the actions requested could be carried out with existing resources under the programme budget.

Dr KIENY (Assistant Director-General) said that with existing resources the Secretariat would be unable to provide technical support but would be able to develop the proposed global strategy, as much of the research would be undertaken by the Global Health Workforce Alliance and supported by other partners.

Dr NITHIMA SUMPRADIT (Thailand), supporting the amendment proposed by the delegate of Japan, agreed to withdraw her amendment to the third paragraph of the draft resolution. However, she felt there was support for the other amendments proposed.

The CHAIRMAN reminded the delegate of Thailand that the delegates of Switzerland and Australia had requested that all amendments be withdrawn.

Mrs NAARENDORP (Suriname) asked for the discussion to be suspended so that the proposed amendments could be circulated in writing.

Mr KLEIMAN (Brazil) said that, although he understood the request made by the delegate of Suriname, discussions on the draft resolution had been ongoing for a year and convening a drafting group would be unfortunate. He called on the delegate of Thailand and others to show flexibility and approve the draft resolution.

Mr COTTERELL (Australia), in the spirit of flexibility, agreed to the amendment proposed to the second preambular paragraph but could not accept the proposed new preambular paragraph without seeing it in writing or having it re-read.

Dr ONDARI (Secretary) re-read the proposed new preambular paragraph.

Mr COTTERELL (Australia) said that significant consultations would be required in order to accept that new preambular paragraph.

Dr NITHIMA SUMPRADIT (Thailand), recognizing that other preambular paragraphs already referred to the Kampala Declaration and the WHO Global Code of Practice, agreed to withdraw her proposal to add the new preambular paragraph.

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

The draft resolution, as amended, was approved.¹

4. PREPAREDNESS, SURVEILLANCE AND RESPONSE: Item 16 of the Agenda

Antimicrobial drug resistance: Item 16.5 of the Agenda (Documents A67/39, A67/39 Add.1 and EB134/2014/REC/1, resolution EB134.R13) (transferred from Committee A)

The CHAIRMAN invited the Committee to consider the draft resolution contained in resolution EB134.R13.

¹ Transmitted to the Health Assembly in the Committee's fourth report and adopted as resolution WHA67.24.

Dr AMMAR (Lebanon) recalled that the extensive use, misuse and overuse of antimicrobials in human and animal health and the food production chain had resulted in antimicrobial resistance. With increasing travel and trade in food, drug resistance could spread internationally, constituting a serious threat to global health security and requiring a global response led by WHO. The 2001 WHO global strategy for containment of antimicrobial resistance had not had the desired impact and required further commitment from Member States and greater intersectoral collaboration, including with FAO and OIE. He therefore supported the recommendations of the Strategic and Technical Advisory Group on antimicrobial resistance and the next steps set out in the Secretariat's report. In addition, self-medication and over-the-counter dispensing of antimicrobials, which were widespread in many developing countries, should be addressed. He supported the draft resolution and asked for his country to be added to the list of sponsors.

Professor BAGGOLEY (Australia) was pleased that Australia was a sponsor of the draft resolution. Antimicrobial resistance was a threat to global security and should therefore be tackled by all countries. He welcomed the leadership role played by WHO and the efforts made by the United Kingdom of Great Britain and Northern Ireland, Sweden and other sponsors of the draft resolution to keep attention focused on that threat. His country had committed resources to prevent and contain antimicrobial resistance and was developing a national strategy. He supported the scope, content and process for stakeholder investment proposed by the Secretariat, which would further the development of a new global action plan. It was time to move from advocacy to action.

Dr ZHOU Jun (China) said that the Secretariat and Member States had been working to combat antimicrobial resistance with some success; however, the situation remained daunting, and national and regional responses varied. China attached great importance to the rational use of antibiotics and had enacted legislation to regulate the supply chain and ensure market surveillance. Moreover, the use of antimicrobials was supervised in all hospitals in China. As a result of those measures, awareness had been raised in medical institutions and among health care workers, and indicators of antimicrobial resistance and the use of antimicrobials had improved. As there remained a need for international, multisectoral cooperation, he supported the next steps set out in the Secretariat's report and the draft resolution.

Mr HO (Singapore) said that antimicrobial resistance was as important as any other public health issue. As a global problem, antimicrobial resistance required a global solution. He commended WHO's efforts to guide the response and raise awareness, including through the theme of World Health Day 2011. The first ever global surveillance report on antimicrobial resistance, released in April 2014, had mapped the magnitude of the problem and the current global state of surveillance. The sponsors of the draft resolution, particularly the United Kingdom of Great Britain and Northern Ireland and Sweden, were to be thanked for their efforts in driving the issue forward. He supported proposals for a global action plan, which would facilitate the move from advocacy to action and encourage collective efforts. He asked for Singapore to be added to the list of sponsors of the draft resolution.

Dr NITHIMA SUMPRADIT (Thailand) welcomed the establishment of a WHO global advisory group on antimicrobial resistance and the tripartite cooperation between WHO, FAO and OIE. She fully supported the draft resolution, of which her country was a sponsor. Antimicrobial resistance had emerged as a major global public health issue, and efforts to address that issue at the national and international levels demonstrated the size of the problem and the need for collective global action. The draft resolution rightly called for monitoring of the use of antibiotics in all relevant sectors, in particular health and agriculture, but she wished to emphasize their use in aquaculture and companion animals; those issues should be included in the proposed global action plan. The effective management of antimicrobial resistance required strong political commitment and intersectoral action to prevent and control infection, and to secure access to and make rational use of effective antimicrobials. In that

regard, she agreed that a high-level meeting should be convened to ensure political commitment, and she called on WHO to develop the global action plan on antimicrobial resistance for submission to the Sixty-eighth World Health Assembly.

Mr AL-RUMAIHI (Qatar) recalled that leading experts on antimicrobial resistance had gathered in Doha in 2013 and had reiterated the need to tackle antimicrobial resistance immediately, as increasing resistance and a lack of new medications would lead to a growing number of untreatable infections. Their report indicated possible actions to combat antimicrobial resistance, including collaboration, policy guidance, surveillance, technical assistance, and innovative research and development. He supported the draft resolution and urged others to approve it.

Mr EIDE (Norway) welcomed the report and recalled resolution WHA66.22, which had been a first step towards improving financing and coordination for research and development of technologies, including antimicrobials. Renewed action in that regard was welcome, and he strongly supported the draft resolution. The global action plan to be presented at the Sixty-eighth World Health Assembly should contain specific and actionable steps to be taken. Consultations with Member States on the draft global action plan would be useful; Norway offered to co-host a meeting to discuss how countries could strengthen their efforts to both secure access and promote responsible use of antimicrobials. However, Member States should not wait for the global action plan before acting.

Ms DUSSEY-CAVASSINI (Switzerland)¹ asked for Switzerland to be added to the list of sponsors of the draft resolution. The response to antimicrobial resistance had to be multisectoral, and Switzerland was developing a national programme (to be finalized in 2015) bringing together all relevant sectors and stakeholders with the aims of conducting surveillance of antimicrobial resistance, reducing use of antibiotics and ensuring their rational use, preventing resistant infections, and raising awareness. However, the response should also be global and led by WHO; Switzerland was therefore committed to combating antimicrobial resistance through its cooperation programmes on research and development.

Ms PADILLA RODRÍGUEZ (Mexico) recognized the need for stronger measures to contain antimicrobial resistance at global level, taking regional specificities into account. Antimicrobial resistance had become a significant public health issue, impacting the global economy. With a view to reducing the use of antimicrobials, strategies to prevent and control infection should focus on health and hygiene. She acknowledged the recommendation of the Strategic and Technical Advisory Group on antimicrobial resistance for multisectoral action to develop and implement new diagnostic tools, treatment options, and business models for the creation of new antimicrobials. On behalf of the sponsors of the draft resolution, of which her country was one, she proposed that the phrase “taking into account the need to manage potential conflicts of interest” should be added at the end of subparagraph 2(6).

Ms KEKEMPANOU (Greece), speaking on behalf of the Member States of the European Union, acknowledged the urgency of addressing antimicrobial resistance, especially antibiotic resistance. The first global surveillance report on antimicrobial resistance, which had proved the scale of the problem, was welcome: WHO had a crucial role to play in surveillance and in monitoring the use of antibiotics in human health. Antimicrobial resistance should be a part of WHO’s regular epidemiological surveillance, taking into account the work of other international partners. Global action on antimicrobial resistance was needed at the highest political level, under the leadership of WHO. Antimicrobial resistance could only be contained with multisectoral action at all levels, and the

¹ At the invitation of the Chairman and in the interests of good timekeeping, this statement was not delivered in full at the meeting.

European Union was implementing an integrated action plan in that regard. WHO's activities should include support to prevent health care-associated infections, ensuring patient safety and the prudent use of antibiotics while mitigating the risk of further resistance. She supported the development of a global action plan and welcomed the contribution of the Strategic and Technical Advisory Group. She fully supported the draft resolution as amended by the delegate of Mexico, noting that the European Union had already been added to the list of sponsors.

Dr SMEU (Libya) speaking on behalf of the Member States of the Eastern Mediterranean Region, thanked the Secretariat for the reports and welcomed the draft resolution. He recognized that there were problems with respect to mortality following surgical interventions or cardiac surgery.

Dr SHAHANIZAN MOHD ZIN (Malaysia) congratulated WHO for its leadership role in containing antimicrobial resistance: there was a need for raised awareness and urgent action at the highest political level, nationally and globally. Promotion of sanitation, hygiene and infection prevention and control practices, including the use of vaccines, was essential. Innovative business models were also required to support a long-term approach to the development, production and use of antimicrobials, and innovations in service delivery and social mobilization should be encouraged. Collaboration should focus on capacity-building and developing health promotion, education and communication programmes so as to change the culture and the demand for antimicrobials. Containment of antimicrobial resistance would require multisectoral collaboration and resources. She supported the draft resolution, of which her country was a sponsor.

Dr RANJAN (India), noting that antimicrobial resistance was increasing the number of untreatable infections, supported the development of a global action plan in collaboration with all partners and stakeholders, while avoiding conflicts of interest. Antimicrobial resistance was a priority for India. In the face of resistance to tuberculosis, HIV and hepatitis treatments, it was becoming more urgent to prevent the transmission of infectious diseases. The global action plan must address financial access to new antibiotics in developing countries, funding for research and development in the developing world, and transfer of technologies. It was important to identify needs and provide financial and technical resources to build capacity in developing countries, including laboratory surveillance; networks would also need to be built up in order to produce comparable data and inform evidence-based treatment guidelines. He supported the draft resolution.

Mr PRUMMER (Austria) commended WHO's activities on antimicrobial resistance and emphasized the importance of a multisectoral approach. In Austria, cooperation between relevant sectors was facilitated by national legislation, under which the Federal Ministry of Health had administrative responsibility. An intersectoral national action plan against antimicrobial resistance had been adopted in 2013, defining responsibilities and tasks in each relevant sector. He looked forward to the global action plan, which would support national strategies, and he asked for Austria to be added to the list of sponsors of the draft resolution.

Ms HALÉN (Sweden) said that antimicrobial resistance had long been a political priority for Sweden both nationally and globally, and she therefore appreciated the support for the draft resolution. Antimicrobial resistance was a complex problem that called for a cross-sectoral approach combined with sustained global commitment. Growing resistance posed a threat in all countries, and capacity-building was particularly important in developing countries. WHO's leadership and the proposed global action plan were crucial. She urged Member States to engage actively in the development of that global action plan, supported by the Secretariat. In that regard, Sweden would host an expert meeting on surveillance, in cooperation with WHO, to build on the first global surveillance report on antimicrobial resistance. She supported the draft resolution, as amended.

Mr VEGA MOLINA (Spain) supported the development of a global action plan and thanked the United Kingdom of Great Britain and Northern Ireland and Sweden for their leadership in preparing the draft resolution. He agreed that the increase in antimicrobial resistance and its economic consequences required urgent action, and most appropriately through an intersectoral and multidisciplinary approach that brought together regulatory authorities, industry, professionals and academics. The response to antimicrobial resistance entailed closer surveillance, better pharmaceutical regulation, infection prevention and control, technological innovation, training and education. In line with European Union initiatives, Spain had developed a multisectoral strategic action plan to reduce antimicrobial resistance, which incorporated human and veterinary medicine.

Mrs TYSON (United Kingdom of Great Britain and Northern Ireland) thanked Member States for their support for the draft resolution, which indicated that the world was ready to act on antimicrobial resistance. Support from various regions had confirmed that the problem was not confined to developed or developing countries but was a global one. There was a need for more rational use of antimicrobials, improved surveillance, and enhanced research and development. She recognized the legitimate concerns of developing countries regarding the need for access to affordable antibiotics, the challenge of balancing that with more rational use, and the need to build technical capacity in laboratories or in surveillance. Recognizing the scale of the challenge, she looked forward to working with others to develop a global action plan that addressed the needs of all Member States. She urged the Committee to approve the draft resolution.

Dr GYANSA-LUTTERODT (Ghana), speaking on behalf of the Member States of the African Region, welcomed the timely release of the first global report on surveillance. Antimicrobial resistance threatened global health security, especially for countries with weaker surveillance and laboratory capacity, as well as the long-term sustainable control of many communicable diseases, including tuberculosis, malaria and HIV/AIDS. It therefore required a global response. A number of countries had already developed national action plans and others were urged to do so. Moreover, countries should strengthen regulatory mechanisms to maintain and support innovation and research for new antibiotics. Policy-makers, academics, research institutions and industry should work together to ensure sustainable financing for research and development of new antibiotics. Greater collaboration and coordinated efforts at global and regional levels, such as the Field Epidemiology and Laboratory Training Program in Africa, were crucially important to control the increase in multidrug and antimicrobial resistance.

WHO should lead the development and coordination of the proposed global action plan, which should highlight the prevention and control of antimicrobial resistance in all health systems and practices, the rational use of antimicrobials, and the need for hygiene and infection prevention and control. The global action plan should also recognize the specific needs of developing countries, namely for training and capacity-building, financial and technical support, and access to new antibiotics and diagnostics. She supported the draft resolution, and looked forward to consultations on the global action plan.

Mr ESIN (Russian Federation), speaking also on behalf of Armenia, Belarus, Kazakhstan, Kyrgyzstan and Uzbekistan, said that antimicrobial resistance required a response that incorporated all affected sectors. He supported the proposed tripartite collaboration between WHO, FAO and OIE. In view of the growth in resistance of infectious diseases, including tuberculosis, and the fact that in many cases alternative medicines did not exist, antimicrobial resistance was a priority for the Member States of the Commonwealth of Independent States. As well as developing new antimicrobial and antiviral medicines at global, regional and national levels, it was essential to take steps to ensure the rational use of antibiotics. In the Commonwealth of Independent States, various measures were being taken to combat antimicrobial resistance, and its members had experience of measures to control the use of antibiotics and to monitor pathogen resistance, which could have a significant impact on containing antimicrobial resistance. He supported the draft resolution, as amended.

Dr KHAWAJA (Bahrain) said that antimicrobial resistance was one of the priorities of her country. Antimicrobial drugs were made available by the State and were therefore relatively cheap. It was important to improve their use. WHO had a major role to play, notably through the Secretariat supporting Member States in establishing the necessary infrastructure to deal with the problem. She supported the draft resolution.

Ms ST LAWRENCE (Canada) welcomed the leadership of the United Kingdom of Great Britain and Northern Ireland in preparing the draft resolution. Her country remained committed to working with domestic and international partners to reduce, limit and control the emergence and spread of resistant pathogens. Current national activities were in line with the proposed global action plan, and she supported the comprehensive approach being proposed. However, the action plan should address viruses such as HIV and influenza, where appropriate, in addition to antibiotic-resistant bacteria. She asked for her country to be added to the list of sponsors of the draft resolution.

Mr KOLKER (United States of America) said that his country was proud to sponsor the draft resolution and he supported the development of a global action plan. Innovative collaboration, including public-private partnerships, should be further explored. Stewardship of antimicrobials was important for their use in humans and animals. The United States Food and Drug Administration had approved limitations on the use of antibiotics in animals. Surveillance was crucial. The Transatlantic Taskforce on Antimicrobial Resistance was a model for collaboration, fostering research and exchange of information on best practices and lessons learnt. He accepted the amendment to the draft resolution proposed by the delegate of Mexico.

Dr Y. PILLAY (South Africa) said that a national strategy on antimicrobial resistance was being developed in South Africa, addressing surveillance and reporting, antimicrobial stewardship, infection prevention and control, and governance. Hand washing was a simple and cost-effective infection control measure, but was not routinely practised. Such interventions, along with the rational use of antibiotics, should be implemented immediately. Effective responses needed accurate surveillance systems, which was a challenge in many developing countries and would require significant investment. Other sectors had a role to play in antimicrobial resistance, such as the agricultural sector with regard to the routine administration of antibiotics to animals. Close multisectoral collaboration was required to address antimicrobial resistance. He supported the draft resolution and asked for his country to be added to the list of sponsors.

Mr FOURQUET (France) recognized the global nature of antimicrobial resistance, which threatened to return humanity to the period before antibiotics existed. The problem required a global response, involving the human health, animal health and environmental sectors. All countries were affected, irrespective of their level of development, and the Secretariat should seek to coordinate and support Member States' efforts. Combating antimicrobial resistance required infection prevention, improved diagnostics, changing the behaviour of health care professionals, and supporting research and innovation. He welcomed the proposed global action plan.

Dr OKABAYASHI (Japan) noted that antimicrobial resistance often spread through hospital-acquired infections and that, in many countries, containment measures were inadequate and the status of antimicrobial resistance was unclear. It was essential that steps be taken to address hospital-acquired infections. In that regard, he wished to propose an amendment to subparagraph 2(5)(e) of the draft resolution, adding the words: "in health care, including hand hygiene, standard precautions and safe injection" after "control" at the end of the subparagraph.

Dr GUTIERREZ (Philippines) supported the draft resolution, which would expedite local, regional and global evidence-based actions to combat antimicrobial resistance. His country had responded to the WHO six-point policy package on antimicrobial resistance by issuing an

administrative order, and an interagency committee had been created to develop and implement a comprehensive multisectoral national plan on antimicrobial resistance. Effective regulation of the quality and use of antimicrobials, together with education for health care providers on rational use of medicines and patient compliance, formed the basis of the national approach. It was also important to improve antimicrobial resistance surveillance in the Western Pacific Region.

Mr RIETVELD (Netherlands) fully supported the development of a global action plan. Experience in his country had proven that immediate joint action was required, strengthening international cooperation while recognizing national responsibilities. Member States should cooperate with other countries, the Secretariat, FAO and OIE, under the leadership of WHO. His country was committed to finding solutions to the global problem of antimicrobial resistance and had offered to host a meeting later that year, supported by the Secretariat. He supported the draft resolution as amended by the delegate of Mexico and thanked those Member States that had worked to prepare it.

Mr KLEIMAN (Brazil) supported the draft resolution, which had to reflect the regional use and cost-effectiveness of antimicrobial medicines. He noted that the Netherlands had offered to host, along with the Secretariat, a ministerial meeting for development of the global action plan.

Ms JUMA (United Republic of Tanzania) welcomed the draft resolution and the proposal to develop a global action plan and commended the work of the Strategic and Technical Advisory Group on antimicrobial resistance that had been convened by the Director-General. The increasing burden of antimicrobial resistance had also been seen in her country, in the loss of first line antibiotics as a result of irrational prescribing, self-medication, SSFFC medical products and use of antibiotics in animals. Increasing antimicrobial resistance would affect the achievement of universal health coverage and the post-2015 health-related development goals, as well as a sustainable public health response to communicable diseases. She urged the Secretariat to meet the needs of developing countries in building capacity and ensuring affordable access to new products to treat resistant pathogens.

Mr KIM Young-hak (Republic of Korea) supported the draft resolution. In view of the varying antibiotic use in different countries, there was a need to establish global standards on surveillance, data collection and reporting. Countries should share their experience and ideas on multisectoral action, prevention of the misuse and abuse of antibiotics, and control of health care-related infections. His country would continue to support WHO's efforts to combat antimicrobial resistance.

Ms MUTIARANI (Indonesia) acknowledged the global and regional efforts made to address the growing problem of antimicrobial resistance, including the 2011 Jaipur Declaration on Antimicrobial Resistance, and a regional workshop on rational use of antimicrobials hosted by Indonesia in 2012. A national focal point had been designated to coordinate activities on antimicrobial resistance, and national multistakeholder plans, strategies and regulations were being drawn up. It was important to develop novel diagnostics and antimicrobial medicines and to ensure continued support for, and surveillance of, patients in all health care settings and in the community. Challenges with regard to institutional capacity, human resources, finance, and infrastructure had to be overcome if the goals on antimicrobial resistance were to be met. She supported the draft resolution.

Dr BAŞÇI (Turkey) noted that antimicrobial use and antimicrobial resistance differed considerably among countries and among regions within countries; it was therefore important to adopt approaches that first sought to understand the causes of region-specific problems and then provided tailored evidence-based solutions, with the active participation of stakeholders. Sharing experiences and international cooperation would benefit many countries. In Turkey, multisectoral activities to reduce the irrational use of antimicrobial agents were carried out under a national action plan on rational drug use. A more specific strategy and action plan were being prepared to contain antimicrobial resistance, including surveillance and legislation on animal health, antimicrobials used

in agriculture and antimicrobial resistance in animals. The national prescription information system yielded data on national antibiotic use, which were reported through methodology used in the European Surveillance of Antimicrobial Consumption network. National antimicrobial resistance data were also calculated and reported in line with the Central Asian and Eastern European Surveillance of Antimicrobial Resistance network.

Comprehensive national programmes, which included international cooperation and took account of regional specificities, were essential to combat antimicrobial resistance. A WHO global action plan would assist Member States in their fight against antimicrobial resistance. He asked for his country to be added to the list of sponsors of the draft resolution and urged Member States to approve it.

Dr PHAM THI CHINH (Viet Nam) said that her country had a national action plan to combat antimicrobial resistance for 2013–2020, which comprised raising awareness, improving national surveillance of antibiotic use and drug resistance, ensuring the quality and supply of medicines, enhancing infection control in health care facilities, and promoting the rational and responsible use of antibiotics in human and animal health. She supported the draft resolution and encouraged Member States to develop national action plans.

Ms BONNER (Germany) said tackling antimicrobial resistance was a priority in her country. A national strategy, developed in 2008 with the collaboration of several federal ministries and other stakeholders, was being adapted to new developments. However, antimicrobial resistance was a global problem, and she therefore supported the development of a global action plan, to be led by WHO. The uncontrolled sale of antibiotics in many countries, a problem that should be addressed in the global action plan, was a matter of particular concern. Germany was prepared to share its national experience with the Secretariat and interested Member States to help shape the global action plan. She supported the draft resolution and asked for her country to be added to the list of sponsors.

Ms Hsiang-Yi HSU (Chinese Taipei) supported the development of a global action plan and WHO's efforts to respond to the global threat of antimicrobial resistance. To ensure the appropriate use of antibiotics and infection control, an antimicrobial stewardship project had been launched in 2012. The preliminary results of that project indicated a reduction in bacteria in clinical specimens, inpatient antibiotic use and health care-associated infections in hospitals. Chinese Taipei was willing to contribute to the global response to antimicrobial resistance by sharing its experience and expertise.

Ms KUSYNOVÁ (International Pharmaceutical Federation), speaking at the invitation of the CHAIRMAN, said that antimicrobial resistance had been a priority for her organization since 2000. Antimicrobial resistance required a global action plan. Antimicrobial medicines should only be available by prescription and legislative and regulatory controls should be strengthened. Only authorized channels of distribution should be used, in order to minimize the availability of SSFFC medical products. Pharmacists should be used to their full potential in the selection, procurement, distribution and use of antimicrobials. Moreover, all health care professionals should be involved in education campaigns on the appropriate use of antimicrobial agents. A joint statement by her Federation and WHO had empowered pharmacists to take on new roles in treating tuberculosis, and a similar model should be used to address antimicrobial resistance.

Dr KAUR (Stichting Health Action International), speaking at the invitation of the CHAIRMAN, said that the antibiotic resistance crisis required global leadership from WHO. Member States should therefore ensure that WHO had sufficient resources to fulfil its vital leadership role. The Director-General should consider a framework convention as a core component of the global action plan. Member States should commit to developing and implementing specific, measurable and realistic targets for the reduction of antibiotic resistance. The global action plan and the draft resolution should incorporate the following recommendations: to end the use of antibiotics for animal growth promotion

and routine disease prevention; to introduce comprehensive monitoring of antibiotic resistance, including baseline surveys of the availability and use of antibiotics; to strengthen innovation with regard to new antibiotics; and to specifically mention the need to curb all forms of promotion of antibiotics.

Mr OTTIGLIO (International Federation of Pharmaceutical Manufacturers and Associations), speaking at the invitation of the CHAIRMAN, said that a global multifaceted approach was needed to address antimicrobial resistance. The paucity of new antibiotic approvals was the tip of the iceberg. To address the scientific challenges holding back the discovery of new antibiotics, the drug discovery infrastructure would require sustained rebuilding and funding by governments, academia and industry. The efforts made by regulatory agencies to create regulatory pathways that facilitated the development of novel antibiotics were to be commended. Risk reduction mechanisms and incentives were also required to encourage investment in new diagnostic tools. Public–private partnerships were indispensable for promoting the development of new medicines, facilitating knowledge sharing and offsetting the challenges of clinical development. New antibiotic development should be complemented by measures to ensure their appropriate prescription and use.

Ms GOPFERT (International Federation of Medical Students' Associations), speaking at the invitation of the CHAIRMAN, said that she had personal clinical experience of the increasing threat of antimicrobial resistance. She welcomed Member States' urgency in addressing the crisis and their commitment to containment. However, the development pipeline for antibiotics was almost empty, as intellectual property was not an effective incentive for new antibiotic research, owing to limited income potential. In order to develop affordable new antibiotics, research and development models should include open-source research, delinked financing, and end products openly licensed as global public goods, and the global observatory for health research and development should coordinate that effort. However, as the development of new medicines would take up to 20 years, Member States were urged to commit to new research models straight away and to include innovative research and development models in the global action plan.

Ms PATEL (International Pharmaceutical Students' Federation), speaking at the invitation of the CHAIRMAN, said that antimicrobial resistance required immediate collaborative solutions, and she therefore supported the proposed global action plan and draft resolution. Greater investments should be made in developing novel antimicrobial medicines through new research and development models. Antimicrobial resistance could only be addressed by joint innovation efforts. The implementation of regulatory instruments, as proposed in the work plan on SSFFC medical products, would help to combat illicit antimicrobials, as would increased education and availability of assessment tools. There was evidence that antimicrobial resistance was present in communities where such medicines could be obtained without a prescription. Stricter enforcement of prescription and dispensation compliance, and implementation of the guidelines on good pharmacy practice issued jointly by WHO and the International Pharmaceutical Federation, were therefore required.

Dr FUKUDA (Assistant Director-General) thanked Member States for their sense of urgency, their support of the draft resolution and their comments, which had underscored the scale, scope and complexities of the problem. Antimicrobial resistance had become an urgent and transformational public health issue for two reasons: because its impact and implications were unacceptable, and because the actions required called for deep intersectoral collaboration. When faced with the question of how to move forward, there were two choices: a fragmented, isolated approach, or a coordinated one, pooling global experience and resources. Member States had agreed that there was only one answer: to develop a multisectoral global action plan that addressed the concerns of all stakeholders, reflected Member States' input, and incorporated the "One Health" concept. The global action plan would build on existing work and lessons learnt. Research and innovation should be used to close the gaps in knowledge and tools. The plan should adequately address the issue of preventing hospital-

acquired infections, a concern which had been raised by the delegate of Japan. It should recognize that developing countries had important and particular needs, in terms of both capacity and affordable access. And finally it had to balance the need to reduce the misuse of antimicrobial medicines with the need to improve research and development, covering bacteria and other emerging pathogens. The global action plan would be a key vehicle in WHO's effort to move from advocacy to action. The draft resolution called for the global action plan to be presented to the Sixty-eighth World Health Assembly; while a year was not very long, work had already begun, and the Organization would succeed in that endeavour. The global action plan would need to be able to evolve to address future needs. The work to be undertaken required political support from Member States, as well as technical support and financing.

Dr OKABAYASHI (Japan), responding to a request from the CHAIRMAN, thanked Dr Fukuda for his explanation, which met his concern.

At the request of the CHAIRMAN, Dr ONDARI (Secretary) read out the proposed amendment.

The CHAIRMAN took it that the Committee wished to approve the draft resolution contained in Executive Board resolution EB134.R13, as amended by the delegate of Mexico.

The draft resolution, as amended, was approved.¹

5. FOURTH REPORT OF COMMITTEE B (Document A67/73)

Dr SINGH (Nepal), Rapporteur, read out the draft fourth report of Committee B.

The report was adopted.²

6. CLOSURE OF THE MEETING

After the customary exchange of courtesies, the CHAIRMAN declared the work of Committee B completed.

The meeting rose at 17:45.

¹ Transmitted to the Health Assembly in the Committee's fourth report and adopted as resolution WHA67.25.

² See page 350.

PART II

REPORTS OF COMMITTEES

In the following sections, information has been drawn from the relevant Health Assembly report. That report is identified by its document number and publication date, which are provided in square brackets under each subheading. Square brackets have also been used in the reports of Committee A and Committee B to indicate where the text of resolutions and decisions recommended and subsequently adopted by the Health Assembly has been replaced by the respective resolution or decision number. 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

Report¹

[A67/63 – 21 May 2014]

The Committee on Credentials met on 20 May 2014. Delegates of the following Member States were present: Chile; Democratic People's Republic of Korea; Ethiopia; Iceland; Iraq; Japan; Malaysia; Monaco; Portugal.²

The Committee elected the following officers: Dr Feisul Idzwan Mustapha (Malaysia) – Chairman, and Dr Guy Fones (Chile) – 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.

Signed by the Officers of the Committee on Credentials, 20 May 2014:

Chairman: Dr F.I. Mustapha, Malaysia

Vice-Chairman: Dr G. Fones, Chile

States whose credentials it was considered should be recognized as valid (see fourth paragraph above and decision WHA67(6)):

Afghanistan; Albania; Algeria; Andorra; Angola; Argentina; Armenia; Australia; Austria; Azerbaijan; Bahamas; Bahrain; Bangladesh; Barbados; Belarus; Belgium; Benin; Bhutan; Bolivia (Plurinational State of); Bosnia and Herzegovina; Botswana; Brazil; Brunei Darussalam; Bulgaria; Burkina Faso; Burundi; Cabo Verde; Cambodia; Cameroon; Canada; 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;

¹ Approved by the Health Assembly at its sixth plenary meeting.

² See decision WHA67(1).

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; Kyrgyzstan; 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; 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; 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; Venezuela (Bolivarian Republic of); Viet Nam; Yemen; Zambia; Zimbabwe.

GENERAL COMMITTEE

Report¹

Election of Members entitled to designate a person to serve on the Executive Board

At its meeting on 21 May 2014, the General Committee, in accordance with Rule 100 of the Rules of Procedure of the World Health Assembly, drew up the following list of 10 Members, in the English alphabetical order, to be transmitted to the Health Assembly for the purpose of the election of 10 Members to be entitled to designate a person to serve on the Executive Board: China, Democratic Republic of the Congo, Eritrea, Gambia, Kuwait, Liberia, Nepal, Russian Federation, United Kingdom of Great Britain and Northern Ireland, and United States of America.

In the General Committee's opinion these 10 Members would provide, if elected, a balanced distribution of the Board as a whole.

COMMITTEE A

First report²

[A67/62 – 20 May 2014]

Committee A held its first meeting on 19 May 2014 under the chairmanship of Dr Pamela Rendi-Wagner (Austria).

In accordance with Rule 34 of the Rules of Procedure of the World Health Assembly, the Committee elected Professor Pe Thet Khin (Myanmar) and Dr Jorge Villavicencio (Guatemala) as Vice-Chairmen, and Dr Helen Mbugua (Kenya) as Rapporteur.

¹ Approved by the Health Assembly at its eighth plenary meeting, see decision WHA67(7).

² Approved by the Health Assembly at its sixth plenary meeting.

It was decided to recommend to the Sixty-seventh World Health Assembly the adoption of one resolution relating to the following agenda item:

12. Communicable diseases

- 12.1 Draft global strategy and targets for tuberculosis prevention, care and control after 2015 [WHA67.1].

Second report¹

[A67/64 – 21 May 2014]

Committee A held its second and third meetings on 20 May 2014 under the chairmanship of Dr Pamela Rendi-Wagner (Austria) and Dr Jorge Villavicencio (Guatemala).

It was decided to recommend to the Sixty-seventh World Health Assembly the adoption of one resolution and one decision relating to the following agenda items:

11. WHO reform

- 11.2 Improved decision-making by the governing bodies [WHA67.2]
11.4 Follow-up to the financing dialogue [WHA67(8)].

Third report¹

[A67/65 – 22 May 2014]

Committee A held its fourth and fifth meetings on 21 May 2014 under the chairmanship of Professor Pe Thet Khin (Myanmar) and Dr Pamela Rendi-Wagner (Austria).

It was decided to recommend to the Sixty-seventh World Health Assembly the adoption of one decision relating to the following agenda item:

13. Noncommunicable diseases

- 13.2 Maternal, infant and young child nutrition [WHA67(9)].

Fourth report²

[A67/68 – 23 May 2014]

Committee A held its sixth and seventh meetings on 22 May 2014 under the chairmanship of Dr Pamela Rendi-Wagner (Austria).

It was decided to recommend to the Sixty-seventh World Health Assembly the adoption of one resolution relating to the following agenda item:

12. Communicable diseases

- 12.3 Hepatitis [WHA67.6].

¹ Approved by the Health Assembly at its eighth plenary meeting.

² Approved by the Health Assembly at its ninth plenary meeting.

Fifth report¹

[A67/70 – 24 May 2014]

Committee A held its eighth, ninth and tenth meetings on 23 May 2014 under the chairmanship of Dr Pamela Rendi-Wagner (Austria) and Professor Pe Thet Khin (Myanmar).

It was decided to recommend to the Sixty-seventh World Health Assembly the adoption of three resolutions relating to the following agenda items:

- 13. Noncommunicable diseases
 - 13.3 Disability [WHA67.7]
 - 13.4 Comprehensive and coordinated efforts for the management of autism spectrum disorders [WHA67.8]
 - 13.5 Psoriasis [WHA67.9].

Sixth report¹

[A67/72 – 24 May 2014]

Committee A held its eleventh and twelfth meetings on 24 May 2014 under the chairmanship of Professor Pe Thet Khin (Myanmar).

It was decided to recommend to the Sixty-seventh World Health Assembly the adoption of six resolutions and two decisions relating to the following agenda items:

- 14. Promoting health through the life course
 - 14.4 Multisectoral action for a life course approach to healthy ageing [WHA67(13)]
 - 14.2 Newborn health: draft action plan [WHA67.10]
 - 14.5 Public health impacts of exposure to mercury and mercury compounds: the role of WHO and ministries of public health in the implementation of the Minamata Convention [WHA67.11]
 - 14.6 Contributing to social and economic development: sustainable action across sectors to improve health and health equity [WHA67.12]
- 16. Preparedness, surveillance and response
 - 16.1 Implementation of the International Health Regulations (2005) [WHA67.13]
- 11. WHO reform
 - 11.3 Framework of engagement with non-State actors [WHA67(14)]
- 14. Promoting health through the life course
 - 14.1 Monitoring the achievement of the health-related Millennium Development Goals – Health in the post-2015 development agenda [WHA67.14]
 - 14.3 Addressing the global challenge of violence, in particular against women and girls [WHA67.15].

¹ Approved by the Health Assembly at its ninth plenary meeting.

COMMITTEE B**First report¹**

[A67/66 – 22 May 2014]

Committee B held its first meeting on 21 May 2014 under the chairmanship of Dr Ruhakana Rugunda (Uganda).

In accordance with Rule 34 of the Rules of Procedure of the World Health Assembly, the Committee elected Dr Mohsen Asadi-Lari (Islamic Republic of Iran) and Dr Siale Akauola (Tonga) as Vice-Chairmen, and Dr Dipendra Raman Singh (Nepal) as Rapporteur.

It was decided to recommend to the Sixty-seventh World Health Assembly the adoption of three resolutions and one decision relating to the following agenda items:

19. Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan [WHA67(10)]
20. Programme budget and financial matters
 - 20.2 Financial report and audited financial statements for the year ended 31 December 2013 [WHA67.3]
 - 20.2 Financial report and audited financial statements for the year ended 31 December 2013 – Supplementary funding for real estate and longer-term staff liabilities [WHA67.4]
 - 20.3 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 [WHA67.5].

Second report²

[A67/69 – 23 May 2014]

Committee B held its second and third meetings on 22 May 2014 under the chairmanship of Dr Ruhakana Rugunda (Uganda) and Dr Siale Akauola (Tonga), respectively.

It was decided to recommend to the Sixty-seventh World Health Assembly the adoption of two resolutions and two decisions relating to the following agenda items:

21. Audit and oversight matters
 - 21.1 Report of the External Auditor [WHA67.16]
22. Staffing matters
 - 22.3 Amendments to the Staff Regulations and Staff Rules [WHA67.17]
 - 22.4 Appointment of representatives to the WHO Staff Pension Committee [WHA67(11)]
23. Management and legal matters
 - 23.2 Real estate: update on the Geneva buildings renovation strategy [WHA67(12)].

¹ Approved by the Health Assembly at its eighth plenary meeting.

² Approved by the Health Assembly at its ninth plenary meeting.

Third report¹

[A67/71 – 24 May 2014]

Committee B held its fourth and fifth meetings on 23 May 2014 under the chairmanship of Dr Ruhakana Rugunda (Uganda), Dr Siale Akauola (Tonga) and Dr Mohsen Asadi-Lari (Islamic Republic of Iran).

It was decided to recommend to the Sixty-seventh World Health Assembly the adoption of two resolutions relating to the following agenda items:

- 15. Health systems
 - 15.1 Traditional medicine [WHA67.18]
 - 15.5 Strengthening of palliative care as a component of integrated treatment throughout the life course [WHA67.19].

Fourth report¹

[A67/73 – 24 May 2014]

Committee B held its sixth and seventh meetings on 24 May 2014 under the chairmanship of Dr Ruhakana Rugunda (Uganda) and Dr Mohsen Asadi-Lari (Islamic Republic of Iran), respectively.

It was decided to recommend to the Sixty-seventh World Health Assembly the adoption of six resolutions and one decision relating to the following agenda items:

- 15. Health systems
 - 15.2 Follow-up of the report of the Consultative Expert Working Group on Research and Development: Financing and Coordination [WHA67(15)]
 - 15.4 Access to essential medicines [WHA67.22]
 - 15.6 Regulatory system strengthening
 - Regulatory system strengthening for medical products [WHA67.20]
 - Access to biotherapeutic products, including similar biotherapeutic products, and ensuring their quality, safety and efficacy [WHA67.21]
 - 15.7 Health intervention and technology assessment in support of universal health coverage [WHA67.23]
 - 15.8 Follow-up of the Recife Political Declaration on Human Resources for Health: renewed commitments towards universal health coverage [WHA67.24]
- 16. Preparedness, surveillance and response
 - 16.5 Antimicrobial drug resistance [WHA67.25].

¹ Approved by the Health Assembly at its ninth plenary meeting.

LIST OF PARTICIPANTS

COMPOSITION DE L'ASSEMBLÉE DE LA SANTÉ MEMBERSHIP OF THE HEALTH ASSEMBLY

LISTE DES DÉLÉGUÉS ET AUTRES PARTICIPANTS LIST OF DELEGATES AND OTHER PARTICIPANTS

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Délégué(s) – Delegate(s)

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Third Secretary, Permanent Mission, Geneva

Mr A.J. Jalil
Third Secretary, Permanent Mission, Geneva

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Mr A. Venter
Director, Management and Accounting,
National Department of Health

Ms S. Singh
Director, Chronic Diseases, Disabilities and
Geriatrics, National Department of Health

Ms N. Malefetse
Director, International Relations, National
Department of Health

Mr S.M. Modisenyane
Director, Africa and Middle East Relations,
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National Department of Foreign Affairs

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Chef adjoint de la délégation – Deputy chief delegate

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Suppléant – Alternate

Ms D. Xhixho
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