



WORLD HEALTH ORGANIZATION

SIXTY-NINTH WORLD HEALTH ASSEMBLY

GENEVA, 23–28 MAY 2016

SUMMARY RECORDS OF COMMITTEES

**REPORTS OF COMMITTEES
LIST OF PARTICIPANTS**

**GENEVA
2016**

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	UNODC	– United Nations Office on Drugs and Crime
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

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

PREFACE

The Sixty-ninth World Health Assembly was held at the Palais des Nations, Geneva, from 23 to 28 May 2016, in accordance with the decision of the Executive Board at its 137th session.¹

¹ Decision EB137(6) (2015).

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¹ Adopted at the second plenary meeting.

² Including election of Vice-Chairmen and the Rapporteur.

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¹ Including election of Vice-Chairmen and the Rapporteur.

- 20.4 [deleted]
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D. Contributing to social and economic development: sustainable action across sectors to improve health and health equity [follow-up of the 8th Global Conference on Health Promotion] (resolution WHA67.12)

E. Reproductive health: strategy to accelerate progress towards the attainment of international development goals and targets (resolution WHA57.12)

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F. Health intervention and technology assessment in support of universal health coverage (resolution WHA67.23)

G. Access to essential medicines (resolution WHA67.22)

¹ Moved from the programme of work of Committee A to that of Committee B further to decision EB138(11) (2016).

- H. Access to biotherapeutic products, including similar biotherapeutic products, and ensuring their quality, safety and efficacy (resolution WHA67.21)
- I. WHO strategy on research for health (resolution WHA63.21)

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A69/4	Overview of reform implementation
A69/5	Member State consultative process on governance reform
A69/6	Framework of engagement with non-State actors ²
A69/7	Maternal, infant and young child nutrition
A69/7 Add.1	Maternal, infant and young child nutrition Guidance on ending the inappropriate promotion of foods for infants and young children ³
A69/7 Add.2	Maternal, infant and young child nutrition United Nations Decade of Action on Nutrition (2016–2025)
A69/8	Report of the Commission on Ending Childhood Obesity ⁴
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A69/10	Prevention and control of noncommunicable diseases: responses to specific assignments in preparation for the third High-level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases in 2018
A69/11	Strengthening synergies between the World Health Assembly and the Conference of the Parties to the WHO Framework Convention on Tobacco Control

¹ See page xi.

² See document WHA69/2016/REC/1, Annex 5.

³ See document WHA69/2016/REC/1, Annex 4.

⁴ See document WHA69/2016/REC/1, Annex 12.

⁵ See document WHA69/2016/REC/1, Annex 2.

A69/11 Add.1	Financial and administrative implications for the Secretariat of resolutions proposed for adoption by the Executive Board or Health Assembly ¹
A69/12	Public health dimension of the world drug problem including in the context of the special session of the United Nations General Assembly on the world drug problem, held in April 2016
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A69/18	Health and the environment Draft road map for an enhanced global response to the adverse health effects of air pollution ⁴
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A69/21 Add.2	Financial and administrative implications for the Secretariat of decisions proposed for adoption by the Executive Board or Health Assembly ⁶

¹ See document WHA69/2016/REC/1, Annex 15.

² See document WHA69/2016/REC/1, Annex 3.

³ See document WHA69/2016/REC/1, Annex 1.

⁴ See document WHA69/2016/REC/1, Annex 11.

⁵ See document WHA69/2016/REC/1, Annex 13.

⁶ See document WHA69/2016/REC/1, Annex 15.

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A69/22	Pandemic influenza preparedness: sharing of influenza viruses and access to vaccines and other benefits
A69/22 Add.1	Pandemic influenza preparedness: sharing of influenza viruses and access to vaccines and other benefits Report of the Special Session of the Pandemic Influenza Preparedness Framework Advisory Group
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A69/25	Poliomyelitis
A69/26	WHO response in severe, large-scale emergencies
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¹ See document WHA69/2016/REC/1, Annex 10.

² See document WHA69/2016/REC/1, Annex 8.

A69/34	Global vaccine action plan
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A69/44 Add.1	Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan Field assessment report on health conditions in the occupied Palestinian territory: summary findings
A69/45	WHO programmatic and financial report for 2014–2015 including audited financial statements for 2015
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¹ See document WHA69/2016/REC/1, Annex 7.

² See document WHA69/2016/REC/1, Annex 9.

³ See document WHA69/2016/REC/1, Annex 14.

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A69/48	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
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¹ See document WHA69/2016/REC/1, Annex 6.

² See document WHA69/2016/REC/1, Annex 8.

³ See document WHA69/2016/REC/1, Annex 15.

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A69/INF./1	Awards
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Diverse documents

A69/DIV./1 Rev.1	List of delegates and other participants
A69/DIV./2	Guide for delegates to the World Health Assembly
A69/DIV./3	Decisions and list of resolutions
A69/DIV./4	List of documents
A69/DIV./5	Instructions on using the electronic voting system for the nomination and appointment of the Director-General
A69/DIV./6	Address by Ms Christiana Figueres, Executive Secretary of the United Nations Framework Convention on Climate Change, to the Sixty-ninth World Health Assembly

OFFICERS OF THE HEALTH ASSEMBLY AND MEMBERSHIP OF ITS COMMITTEES

President

Dr Ahmed Mohammed AL-SAIDI (Oman)

Vice-Presidents

Dr Sathasivam SUBRAMANIAM
(Malaysia)

Dr Francisco TERRIENTES (Panama)

Mr Assane NGUEADOUM (Chad)

Dr Ana Isabel SOARES (Timor-Leste)

Dr Armen MURADYAN (Armenia)

Secretary

Dr Margaret CHAN, Director-General

Committee on Credentials

The Committee on Credentials was composed of delegates of the following Member States: Afghanistan, Bolivia (Plurinational State of), Georgia, Haiti, India, Kenya, Liberia, Madagascar, Poland, Republic of Korea, Spain and Tonga.

Chairman: Ms Katarzyna RUTKOWSKA
(Poland)

Vice-Chairman: Dr Bernice DAHN (Liberia)

Secretary: Ms Françoise MOURAIN-SCHUT,
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 the delegates of the following Member States: Antigua and Barbuda, Argentina, Benin, Cameroon, Central African Republic, China, Côte d'Ivoire, Cuba,

Estonia, France, Iraq, Netherlands, Russian Federation, Somalia, United Kingdom of Great Britain and Northern Ireland, United Republic of Tanzania and United States of America.

Chairman: Dr Ahmed Mohammed AL-SAIDI
(Oman)

Secretary: Dr Margaret CHAN,
Director-General

MAIN COMMITTEES

Under Rule 33 of the Rules of Procedure of the World Health Assembly, each delegation is entitled to be represented on each main committee by one of its members.

Committee A

Chairman: Mr Martin BOWLES (Australia)

Vice-Chairmen: Ms Taru KOIVISTO
(Finland) and Mr Nickolas STEELE
(Grenada)

Rapporteur: Ms Aishah SAMIYA (Maldives)

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

Committee B

Chairman: Dr PHUSIT PRAKONGSAI
(Thailand)

Vice-Chairmen: Dr Mahlet KIFLE (Ethiopia)
and Dr Mohsen ASADI-LARI (Islamic
Republic of Iran)

Rapporteur: Mr Abdunomon SIDIKOV
(Uzbekistan)

Secretary: Dr Clive ONDARI, Coordinator,
Safety and Vigilance

REPRESENTATIVES OF THE EXECUTIVE BOARD

Ms Precious MATSOSO (South Africa)

Dr Rubén Agustín NIETO (Argentina)

Dr Asaad HAFEEZ (Pakistan)

Dr JEON Man-bok (Republic of Korea)

PART I

SUMMARY RECORDS OF MEETINGS OF COMMITTEES

GENERAL COMMITTEE

FIRST MEETING

Monday, 23 May 2016, at 10:20

Chairman: Dr A.M. AL-SAIDI (Oman)
President of the World Health Assembly

1. ADOPTION OF THE AGENDA (document A69/1)

The CHAIRMAN recalled that the terms of reference of the Committee were contained in Rule 31 of the Rules of Procedure of the World Health Assembly.

Deletion of agenda items

The CHAIRMAN said that, if there was no objection, four items on the provisional agenda, which had been prepared by the Executive Board, would be deleted, namely item 5 (Admission of new Members and Associate Members); item 20.4 (Special arrangements for settlement of arrears); item 20.6 (Assessment of new Members and Associate Members); and item 20.7 (Amendments to the Financial Regulations and Financial Rules).

It was so agreed.

The CHAIRMAN said he took it that the Committee wished to recommend the adoption of the agenda, as amended. Its recommendation would be transmitted to the Health Assembly at its second plenary meeting.

It was so agreed.

2. ALLOCATION OF AGENDA ITEMS TO THE MAIN COMMITTEES AND PROGRAMME OF WORK OF THE HEALTH ASSEMBLY (documents A69/1 and A69/GC/1)

The CHAIRMAN, recalling that agenda items were allocated to Committees A and B on the basis of the terms of reference of the main committees and that Committee B usually completed its consideration of the items allocated to it ahead of schedule, drew attention to a proposal by the Executive Board in decision EB138(11) to move provisional agenda items 16 (Health systems) and 17 (Progress reports) from the programme of work of Committee A to that of Committee B, as reflected in the preliminary daily timetable and the provisional agenda. In the absence of any objection, he took it that the Committee could agree to that proposal.

It was so agreed.

The CHAIRMAN said that, given the heavy agenda of the Sixty-ninth World Health Assembly, it would be advisable for the Committee to keep the progress of work under careful review.

Arrangements had been made to allow the plenary meetings on Monday, 23 May and Tuesday, 24 May to continue until 18:30 if necessary, with a view to concluding the general debate on the morning of Wednesday, 25 May; that would in turn allow Committee B to start its work that same morning. In the absence of any objection, he took it that the Committee could agree with those arrangements and with the preliminary daily timetable as amended.

It was so agreed.

The General Committee then drew up the programme of work for the Health Assembly until Wednesday, 25 May.

The CHAIRMAN drew attention to decision EB138(11), whereby the Executive Board had decided that the Sixty-ninth World Health Assembly should close no later than Saturday, 28 May 2016. The preliminary daily timetable therefore provided for the closure of the Assembly on that day. 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 additional speakers should be allowed to take the floor in the order in which they submitted their requests to speak. Those requests 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 should 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 10:30.

SECOND MEETING

Wednesday, 25 May 2016, at 17:35

Chairman: Dr A.M. AL-SAIDI (Oman)
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 A69/GC/2)

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

To assist the General Committee in its task, two documents were before it. The first indicated the present composition of the Executive Board by region, on which list were underlined the names of the 12 Members whose term of office would expire at the end of the Sixty-ninth World Health Assembly and which had to be replaced. The second (document A69/GC/2) contained a list, by region, of the 12 Members that it was suggested should be entitled to designate a person to serve on the Executive Board. Vacancies by region were: African Region: 2; Region of the Americas: 3; South-East Asia Region: 1; European Region: 2; Eastern Mediterranean Region: 2; and Western Pacific Region: 2.

As no additional suggestions 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 took it that the General Committee wished, as was allowed under Rule 78 of the Rules of Procedure, to proceed without taking a ballot.

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 to the Health Assembly the following list of 12 candidates for the annual election of Members entitled to designate a person to serve on the Executive Board: Algeria, Bahrain, Bhutan, Burundi, Colombia, Fiji, Jamaica, Libya, Mexico, Netherlands, Turkey and Viet Nam.

It was so agreed.

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

The representative of AUSTRALIA, speaking in his capacity as Chairman of Committee A, and the representative of THAILAND, speaking in his capacity as Chairman of Committee B, reported on the progress in the work of their respective committees.

The CHAIRMAN proposed a programme of work for Thursday, 26 May; for Friday, 27 May; and for Saturday, 28 May. He made a further proposal to review the 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 of the Health Assembly for Thursday, 26 May; Friday, 27 May; and Saturday, 28 May.

The meeting rose at 17:55.

COMMITTEE A

FIRST MEETING

Monday, 23 May 2016, at 15:30

Chairman: Mr M. BOWLES (Australia)

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

The CHAIRMAN welcomed participants and introduced the representatives of the Executive Board¹ who would report on the Board's consideration of relevant items of the agenda. Any views they expressed would be those of the Board, and not those of their respective governments.

Election of Vice-Chairmen and Rapporteur

Decision: Committee A elected Ms Taru Koivitsu (Finland) and Mr Nickolas Steele (Grenada) as Vice-Chairmen and Ms Aishah Samiya (Maldives) as Rapporteur.²

Organization of work

The CHAIRMAN drew attention to a proposal by the Secretariat to consider item 13.1 (Monitoring of the achievement of the health-related Millennium Development Goals, document A69/14) together with item 13.2 (Health in the 2030 Agenda for Sustainable Development, documents A69/15 and EB138/2016/REC/1, resolution EB138.R5). He also drew attention to a proposal by the Secretariat to consider the first part of item 14.1 (Annual report on the implementation of the International Health Regulations (2005), document A69/20) together with item 14.6 (WHO response in severe, large-scale emergencies, document A69/26) and the second part of item 14.8 (Options for strengthening information-sharing on diagnostic, preventive and therapeutic products and for enhancing WHO's capacity to facilitate access to these products, including the establishment of a global database, starting with haemorrhagic fevers, document A69/29). He said that, if he heard no objection, he would take it that the Committee agreed to those proposals.

It was so agreed.

The representative of the NETHERLANDS, speaking on behalf of the European Union and its Member States, 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. He requested that it should again be invited by the Committee to 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 Committee wished to accede to the request.

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

² Decision WHA69(3).

It was so agreed.

2. WHO REFORM: Item 11 of the agenda

Overview of reform implementation: Item 11.1 of the agenda (document A69/4)

The representative of EGYPT acknowledged the efforts made to implement reform and underscored the importance of taking an integrated approach to the various elements of the reform process and ensuring that steps were taken to rectify the lack of progress in some areas. He expressed concern that the internationally representative character of the Secretariat, as enshrined in Article 35 of the Constitution, had not been properly upheld, given that some 32 Member States remained unrepresented or underrepresented among the Organization's internationally recruited staff.

The Ebola virus disease outbreak had demonstrated the urgent need to finalize and adopt a comprehensive communications strategy, to guarantee the timely and effective communication of risk in times of emergency. Lack of progress in addressing the financial vulnerability of the Organization was cause for concern, particularly since it would affect the new WHO Health Emergencies Programme. He requested clarification with regard to paragraph 26 of the report, on the institutionalization of organizational learning through internal mechanisms, in the light of the recent Member State consultations on governance reform, which had culminated in a decision to recognize the Global Policy Group as an advisory mechanism to the Director-General.

The representative of MOZAMBIQUE, speaking on behalf of the Member States of the African Region, commended the efforts made to implement the reform process thus far, which had already brought improvements in planning and priority setting and the establishment of indicators for organizational outputs linked to measurable health outcomes. She underscored the importance of strengthening the capacities of country offices, which were the first responders in times of crisis. Geographical equity and gender balance must be enhanced in staffing, in particular in managerial positions at headquarters, which would improve the relationship and accountability lines between the three levels of the Organization and enable WHO to respond fully to the needs of its Member States.

The representative of SENEGAL welcomed the progress made over the 5 years since the reform process had begun. He understood that reform was not easy; however, the implementation of the governance and management reforms must be expedited.

The representative of the UNITED KINGDOM OF GREAT BRITAIN AND NORTHERN IRELAND said that WHO had undergone four major reviews and had been subjected to many, far-reaching recommendations for improvement, some of which did not support the reforms that were under way. The United Nations recommendation to establish a Global Health Council constituted a challenge to the Organization. She welcomed the progress made with regard to emergency response reform, the strengthening of the Organization's evaluation function and the introduction of the staff mobility policy. The programme budget web portal also constituted an improvement in transparency, and the plan for WHO to join the International Aid Transparency Initiative at the end of 2016 was welcome. However, gaps remained, especially in respect of the reform of governance, management and programmes.

The representative of CHINA welcomed the steps taken to implement programmatic reform. Noting the improvements made in the financing of the programme budget for the current biennium, which facilitated forward planning, the relative shortage of flexible funding remained a challenge. Governance and management reform were lagging behind; the working methods of the governing bodies required urgent improvement. The number of items on the agendas of the Executive Board and

Health Assembly should be reduced, and greater coherence should be achieved between the agendas of the Board, the Health Assembly and the Programme, Budget and Administration Committee of the Executive Board. Every effort should be made to conclude the discussions on the framework of engagement with non-State actors at the current session of the Health Assembly. Insufficient progress had been made in improving human resources planning: capacity building in the country offices was essential in that regard.

The representative of AUSTRALIA said that the lessons learned from the Ebola virus disease outbreak should continue to inform change with regard to emergency preparedness and response. He encouraged the Secretariat to continue to prioritize management reform, in particular with regard to human resources. Continued constructive cooperation in the area of governance reform would be essential to enable WHO to focus on its core business in a transparent and efficient manner.

The representative of COSTA RICA underscored the urgent need to move forward with governance reform to enhance the efficiency of the governing bodies, particularly in decision-making. With regard to management, recruitment and human resources, processes should be aligned to ensure equitable gender representation in high-level staff positions throughout the Organization, and further efforts should be made to strengthen respect for the values of ethical professional conduct.

The representative of NORWAY said that particular attention should be paid to accountability, especially at the country office level. While he welcomed the Organization's commitment to join the International Aid Transparency Initiative, implement an information disclosure policy and establish an anti-corruption hotline, the slow progress in other areas of reform, such as governance, the framework of engagement with non-State actors and emergency response, had highlighted difficulties in addressing fundamental and longstanding challenges in the Organization's structures and governance. "One WHO" still remained a distant goal and the apparent weaknesses in coordination between the three levels of the Organization gave cause for concern.

The representative of the PHILIPPINES welcomed the efforts to implement emergency reform, which would enable WHO to ensure that its systems and structures were not disrupted by complex health emergencies. Unfortunately, progress in the area of governance reform had been slow and should be accelerated. Lessons could be drawn from successful reform implementation efforts at the regional level.

The representative of IRAQ said that more should be done to optimize the reform process, in particular by improving integration with other international organizations; enhancing collaboration with Member States at the local level; ensuring that resource allocation planning was done in collaboration with countries to ensure that local needs were taken fully into account; reducing management costs and introducing joint monitoring and evaluation; setting contingency workplans at the country level in the event of an emergency; and paying greater attention to the social determinants of health.

The representative of the UNITED REPUBLIC OF TANZANIA welcomed the indicators measuring the achievement of the reform objectives. She noted with concern, however, the lack of progress in the area of governance reform. Donors should be encouraged to provide non-earmarked voluntary contributions to allow WHO to optimize its response to health needs. She supported the proposed way forward on governance reform to ensure accountability at all levels of the Organization, while ensuring that it remained the leading United Nations technical agency on global health matters.

The representative of the UNITED STATES OF AMERICA commended the strides made in programmatic and management reform, which drew on the response to the Ebola virus disease and Zika virus disease outbreaks. Progress had been made in programmatic reform, and she hoped that measures of governance reform would be adopted at the current session. However, the monitoring framework in the annex to document A69/4 was still incomplete. The performance metrics mechanism as a whole, and in particular the indicators, should be objective, measurable and performance-based.

The representative of JAPAN noted with satisfaction that the majority of programmatic reforms had reached the implementation stage; he expressed concern, however, that progress in the area of governance reform had been slower, in particular with regard to coordination across the three levels of the Organization, the effective engagement of non-State actors in operational practices, and human resources reforms to achieve greater diversification of staff.

The representative of MEXICO said that reform must be led by Member States and based on principles of accountability, transparency, efficiency, effectiveness and equity. Progress had been made primarily in programmatic reform; the process was ongoing and required continuous evaluation and reassessment. The lessons learned from the outbreak of Ebola virus disease showed the need for more regular follow-up on the impact of the reforms, in close collaboration with regional offices.

The representative of INDONESIA called for effective discussion leading to recommendations consistent with the WHO Constitution which did not undermine previous resolutions. He welcomed the progress made in institutionalizing planning mechanisms across the Organization; the process should be discussed and harmonized with Member States to ensure a high-quality, sustainable solution. Better communication between country offices and Member States would be important for avoiding asymmetry of information and improving transparency.

The representative of KENYA expressed his support for the reform agenda, and in particular those aspects that would permit the wider participation of non-State actors in WHO activities. He looked forward to the accelerated reform of organizational performance, specifically with regard to human resources, to ensure that the staff employed matched service needs at the country level and that gender equity and geographical diversity were improved at all three levels of the Organization.

The representative of the MALDIVES acknowledged the progress made and work done towards governance reform in the South-East Asia Region, which would enable Member States to engage actively through the Regional Committee and seek guidance on governance matters at the global, regional and country levels.

The representative of the RUSSIAN FEDERATION said that the indicators that had been developed would facilitate the evaluation of the reforms, the Organization's activities and the determination of priorities for the biennium. He welcomed the increasing flexibility of resources and predictability of finances. Progress had been made in programmatic reform despite the technical and operative problems exposed by the Ebola virus disease outbreak, in particular with regard to the availability of human resources.

The representative of the REPUBLIC OF KOREA, while acknowledging the considerable progress that had been made in programmatic reform, called for accelerated reforms of governance, human resources, accountability and information management, and underscored the importance of ensuring transparency and accountability in the reform process at all times. The monitoring and assessment of results was crucial.

The representative of SAUDI ARABIA said that the slow progress in the area of governance reform might jeopardize the effectiveness of the Organization and the overall reform process. In particular, he noted the lack of alignment in terms of priorities at the three levels of the Organization. It was essential to rebuild confidence in the Organization by strengthening the regional offices, building local capacity and helping countries reform their own health systems. Referring to the budget, he said that efforts should be made to broaden the base of contributions and to find financing solutions that were innovative and preserved the Organization's independence.

The representative of BANGLADESH, noting that results had been achieved only in some areas and that the reform process had been interrupted by the outbreak of Ebola virus disease, said that the Secretariat should strengthen its capacity to ensure that its work could continue in all situations. The indicators used to measure reform should be rethought in the light of recent developments such as the Ebola crisis and the adoption of the Sustainable Development Goals. Implementation of the Goals, achieving universal health coverage and building country capacities should be the main priorities. Regarding response to emergencies and disasters, emphasis should be placed on reassessing the existing health systems in countries, taking into account different country contexts and ensuring that sufficient resources were made available.

The representative of THAILAND expressed concern about the lack of progress in the overall implementation of the reform process and in the efforts to increase accountability. Despite improvements in health emergency management, including the new WHO Health Emergencies Programme, further efforts were needed to ensure maximum efficiency and performance in the response to emergencies and crises. It was unclear whether the shortfall of US\$ 160 million required to implement the Programme would be met by voluntary contributions. WHO should complete the reform process and accelerate the implementation of governance reform.

The representative of LIBERIA said that more concrete and sustainable action was necessary to build resilient health services and prevent the occurrence of situations such as the Ebola virus disease outbreak, which had severely affected his country.

The representative of BARBADOS said that governance and management reform should be further addressed by means of renewed discussions with Member States. Regional, subregional and country offices must be strengthened through the allocation of appropriate financial and technical resources and the creation of more robust linkages with WHO. However, the reinforcement of WHO's management and governance systems should not entail centralization. Enhanced management capacities, together with strong oversight and appropriate guidelines, would significantly help the regions to achieve their objectives.

The representative of NICARAGUA said that reform was needed in order to adapt health systems to new developments, especially health emergencies. It should take into account the different developments in the various regions and the capacity for emergency response, and should ensure that regional response capacities were not affected. Local and regional capacities and decision-making should be strengthened. He supported the statement made by the representative of Mozambique on behalf of the Member States of the African Region.

The representative of SOUTH AFRICA welcomed the recent progress in governance reform and stressed the importance of the good alignment of all three levels of the Organization and of sustainable financing. Regional and country offices were key elements in emergency response and the implementation of the Sustainable Development Goals. The monitoring framework annexed to document A69/4 was a valuable aid to accountability.

The representative of UGANDA commended the human resources reforms and said that WHO should ensure that it recruited staff with strong technical, leadership and communication skills, reflecting an appropriate geographical diversity. Senior WHO management and Member States should support the Transformation Agenda launched by the Regional Director for Africa. Strengthening country health systems was the most effective way of combating large-scale disease outbreaks such as the outbreak of Ebola virus disease. Transparency should be ensured in the engagement with non-State actors, with a view to achieving the Sustainable Development Goals.

The representative of GRENADA said that small island States, such as his own, were particularly vulnerable and risked being overlooked if a centralization-based approach to reform was adopted at the expense of strengthening local country offices. The Secretariat should continue to promote strong dialogue to ensure that Member States benefited fully from the reforms.

The representative of PANAMA said that transparency and accountability should be improved at all levels of WHO. Decentralization in favour of the regional and local offices should be increased. Human resources should be strengthened at the country level. Weaknesses had been identified in the financial aspects of the reform, in spite of the financing dialogue: new initiatives should be explored and Member States should fulfil their commitment to provide resources for the Organization. Despite the agreements reached on emergency reform, further work was required to ensure a more rapid response to emergencies, based on national and country office capacities.

The representative of SOMALIA said that the success of the reform should ultimately be judged by performance at the country level. She gave an overview of the implementation of the three reform areas in her country and said that positive results had been achieved. While the efforts undertaken by the Secretariat were commendable, more should be done to promote staff diversity. Reform should not lead to greater centralization of the Organization.

The EXECUTIVE DIRECTOR (Office of the Director-General) noted the calls to accelerate the pace of reform and strengthen work on human resources and accountability, including at the regional office and country office levels. He provided an update of two indicators contained in the annex to the report. For indicator 1.1.4 on delivery of planned outputs, the percentage achieved for 2014–2015 had increased compared with the previous biennium, although a different methodology and budget structure had been used. For indicator 2.1.1 on the provision of governing body documentation within the agreed timeline, the percentage had risen for 2016 compared with 2015, although further improvement was required. The whistleblower hotline was expected to become operational in June 2016.

The report was adopted.

Member State consultative process on governance reform: Item 11.2 of the agenda (documents A69/5 and EB138/2016/REC/1, decision EB138(1))

The representative of ZIMBABWE, speaking in his capacity as Co-Chairperson of the Open-ended Intergovernmental Meeting on Governance Reform, said that the report of the meeting, which was contained in the annex to document A69/5, contained a number of recommendations, which had been agreed upon on the basis of a strong consensus. The meeting had been divided into two main topic areas, namely, the methods of work of the governing bodies and alignment across the three levels of the Organization. He summarized the recommendations on methods of work, drawing particular attention to the need for a forward-looking schedule and better agenda management, the rules concerning additional, supplementary or urgent agenda items and the need to improve information technology tools. He urged the Committee to approve the draft decision appended to the report.

The representative of AUSTRALIA, speaking in his capacity as Co-Chairperson of the meeting, summarized the recommendations on alignment. In addition, he emphasized the importance of continuing discussion and the oversight of governance reform by the governing bodies. Indeed, the Secretariat had produced a road map for future governance reform discussions. He called for approval of the draft decision.

The representative of the NETHERLANDS, speaking on behalf of the European Union and its Member States, expressed disappointment that it had not been possible to make further improvements in the working methods of the governing bodies. He encouraged the Director-General and the regional directors to work further on the recommendations for increased efficiency, transparency, inclusiveness and coherence between the three levels of the Organization. He welcomed the recommendation to make public the documents framing accountability lines between the Director-General and senior staff, as well as those between the three levels of the Organization, but was disappointed that further clarity had not been reached on the issue. Better alignment across all levels of the Organization did not preclude acknowledgement of the diversity of the regions. Lastly, he sought assurance that the ambitions of the Secretariat to hold special funding sessions for the emergency programme would not undermine the general strategic approach of the financing dialogue.

The representative of ARGENTINA, speaking on behalf of the Member States of the Region of the Americas, said that governance reform was essential for achieving WHO reform as a whole within the desired time frame. The meeting had been conducted in a collaborative, consultative, inclusive way and had yielded positive results.

The representative of MONACO expressed her disappointment with the results of the meeting. Consensus had been achieved only on relatively marginal issues in which no real improvements could be observed. It was essential to strengthen the internal governance of WHO and the lines of responsibility between the Director-General and the regional directors. That could only be done through better alignment, a stronger chain of command and greater accountability and transparency.

The representative of IRAQ said that the managerial and supervisory skills of WHO representatives at the country level should be strengthened in order to enhance responsiveness in both routine and emergency situations. Capacity building for WHO representatives should be aligned with capacity building at the regional and headquarters levels, taking into consideration the type of work involved as well as epidemiological, demographic and topographic variables. Experts should be carefully selected and assigned to areas of concern; capacity building for national experts would enable them to take on those tasks. Experts at the country level should be given more independence in respect of the allocation of time and funding. Budgets should be reviewed at the country level in the light of community needs and priorities.

The representative of GERMANY said that WHO should be the key coordinating partner on health issues. However, compared with newer international health organizations, the Organization had problems of budget, efficiency and relevance and was often perceived as being slow-moving, too bureaucratic, very complex, lacking clear internal responsibilities and highly politicized. No consensus had been reached by Member States on addressing those issues. In particular, it had been impossible to achieve alignment between headquarters and the six regions. Greater decentralization might lead to the break-up of the Organization. It was disappointing that no consensus had been achieved on accountability between the Director-General and the regional directors. Although the role of the latter was highly valued, the Organization would never be effective if senior staff could not be held to account by the chief technical and administrative officer. The global governing bodies must provide efficient oversight over work in countries and ensure that country office capacities were adapted to changing needs at the country level. Nevertheless, he supported the draft decision.

The representative of the UNITED REPUBLIC OF TANZANIA supported the recommendation on the long-term planning of the agenda and the handling of additional, supplementary or urgent agenda items. Stricter criteria should be applied for the inclusion of items on the agendas of governing body meetings. She supported the proposal to consult the regional committees further on some of the recommendations before they were submitted to the next session of the Health Assembly.

The representative of ZIMBABWE, speaking on behalf of the Member States of the African Region, said that the report and draft decision represented significant progress in the area of governance reform, which was key to creating a stronger, more efficient, united WHO. Noting that delegations from his Region currently found it difficult to keep up with the business of the governing bodies, he expressed support for the consensus reached on strengthening the working methods of the governing bodies, including with regard to the long-term planning of the agenda, the handling of additional, supplementary or urgent agenda items, the scheduling of governing body meetings and the more effective use of information technology tools. He agreed that there was a need to improve senior leadership coordination and transparency and accountability. While the work of the Global Policy Group was important in that regard, it should not replace or compete with the decision-making prerogative of the Member States. He also supported the proposed reforms related to alignment, which respected the autonomy of the regional committees. More progress could be made at the regional level, for instance, to improve the accountability of Member States and strengthen the oversight roles of the regional committees. Regional and country offices needed more capacity building and resources. Finally, he recommended that the draft guidelines of best practices on governance reform, contained in Appendix III to document EB138/6, which had not been discussed at the meeting for lack of time, should be discarded, since their essence was already covered by the consensus reached on the draft decision.

The representative of THAILAND noted that the recommendations proposed at the meeting included a number of requests to the Director-General to take further action and report on the issues raised, which he believed to be an important element in overall WHO reform. He supported the draft decision.

The representative of EGYPT said that the meeting's recommendations would create a more effective, transparent and accountable Organization across the three levels. Strengthening and streamlining working methods would also allow for the better management of governing body meetings and their agendas, which had increased considerably in length in recent times. He stressed, however, that all three levels of the Organization had their own specific characteristics which must be taken into account. The Director-General's role as the chief technical and administrative officer of WHO did not take precedence over Member States' powers of decision-making and oversight of their respective regional offices.

The representative of BANGLADESH recommended that a time limit should be set for reaching consensus on an agenda item, thus ending the practice of items appearing on the agenda year after year with no action being agreed. When the time limit was reached, a resolution could be adopted based on a partial agreement, with a new resolution adopted subsequently to cover the outstanding issues, or non-critical items could be dropped altogether.

The representative of JAPAN said that, as the senior management of the Organization, assistant directors-general were directly accountable to the Director-General: he therefore sought confirmation that the final decision on their selection would be made by the Director-General.

The representative of COLOMBIA expressed the hope that the recommendations would be endorsed at the current session of the Health Assembly. He welcomed the emphasis on decentralization within the Organization and greater flexibility for the regional offices and the fact that

the draft guidelines reiterated the independence of the regional offices in the context of different regional specificities and needs.

It was vital to strengthen the functioning and working methods of the governing bodies in order to improve their effectiveness and efficiency. There were still clear challenges, including the implementation of decisions, resolutions and plans adopted by those bodies, which necessitated enhanced coordination across the three levels of the Organization and greater transparency and accountability in all processes.

The representative of CHINA said that action needed to be taken without delay, since the work on governance reform had been slow to date. Implementation of the recommendations, in particular regarding the planning and management of the agenda for meetings of the governing bodies, would improve transparency and cooperation across the Organization's three levels. She supported the draft decision and hoped that the Secretariat would adopt measures to implement that decision and advance governance reform as soon as possible. In addition, she hoped that a meeting would be convened as soon as possible to allow Member States to reach agreement on the draft guidelines of best practices on governance reform.

The representative of COSTA RICA expressed support for the draft decision and underscored the importance of implementing the recommendations of the meeting in a timely manner. It was essential to strengthen institutional capacity, planning, accountability, transparency and coordination in WHO, which was a large and complex organization. The process of continuous improvement in those and other areas was vital to ensuring good governance.

The representative of MEXICO welcomed the draft decision but added that it was only the first step in the process of governance reform. Continued reform needed to be based on the ongoing evaluation of the progress achieved and the changes implemented at all three levels of the Organization.

The representative of ETHIOPIA called for the prompt implementation of some of the recommendations, including those related to information technology. Both the Secretariat and Member States should consider the need to set priorities among agenda items and limit the number to be discussed by the governing bodies at each session.

The CHAIRMAN said that he took it that the Committee wished to approve the draft decision contained in the appendix to the report of the Open-ended Intergovernmental Meeting on Governance Reform.

The draft decision was approved.¹

Framework of engagement with non-State actors: Item 11.3 of the agenda (documents A69/6, A69/60 and EB138/2016/REC/1, decision EB138(3))

The representative of the UNITED KINGDOM OF GREAT BRITAIN AND NORTHERN IRELAND, speaking in her capacity as Chairman of the Programme, Budget and Administration Committee of the Executive Board, said that, following the extension of the mandate of the Open-ended Intergovernmental Meeting on the draft framework of engagement with non-State actors by the Executive Board at its 138th session, further discussion of the draft framework had been taken up at a three-day meeting in April 2016. At that meeting, consensus had not been reached on four paragraphs relating to WHO policy and operational procedures on engagement with private sector entities. A

¹ Transmitted to the Health Assembly in the Committee's first report and adopted as decision WHA69(8).

further seven paragraphs had been agreed ad referendum and a number of paragraphs needed further discussion in terms of implementation.

The Programme, Budget and Administration Committee had welcomed the progress made, as the text was mostly complete, and supported the proposal for a drafting group to be established early at the present Health Assembly to finalize both the draft framework and the related draft resolution. The Committee had expressed the expectation that the remaining work could be concluded during the Sixty-ninth World Health Assembly and the framework adopted.

The CHAIRMAN said that he took it that the Committee wished to establish a drafting group to finalize the draft framework of engagement with non-State actors, to be chaired by the representative of Argentina.

It was so agreed.

The CHAIRMAN said that he further took it that the Committee wished to suspend the discussion on item 11.3 pending the outcome of the drafting group.

It was so agreed.

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

The meeting rose at 17:50.

SECOND MEETING

Tuesday, 24 May 2016, at 09:20

Chairman: Mr M. BOWLES (Australia)

later: Mr N. STEELE (Grenada) (Vice-Chairman)

1. NONCOMMUNICABLE DISEASES: Item 12 of the agenda

Maternal, infant and young child nutrition: Item 12.1 of the agenda (documents A69/7, A69/7 Add.1, and A69/7 Add.2)

The CHAIRMAN drew attention to a draft resolution proposed by Ecuador and Peru, which read:

The Sixty-ninth World Health Assembly,

(PP1) Having considered the report on maternal, infant and young child nutrition;¹

(PP2) Recalling resolution WHA68.19 (2015) on the outcome of the Second International Conference on Nutrition, endorsing the Rome Declaration on Nutrition as well as the Framework for Action;

(PP3) Reaffirming the commitments to implement relevant international targets and action plans, including the WHO 2025 Global Nutrition Targets and the WHO's global action plan for the prevention and control of noncommunicable diseases 2013–2020;

(PP4) Recalling United Nations General Assembly resolution 70/1 of 25 September 2015, entitled “Transforming our world: the 2030 Agenda for Sustainable Development”, acknowledging the integrated dimension of the goals and recognizing that to end all forms of malnutrition and address nutritional needs throughout the life course, it is necessary to give universal access to safe and healthy food that is sustainably produced, and to ensure universal coverage of essential nutrition actions;

(PP5) Recalling that the Sustainable Development Goals and targets are integrated and indivisible and balance the three dimensions of sustainable development, and acknowledging the importance of reaching Sustainable Development Goal 2, which aims to end hunger, achieve food security and improved nutrition and promote sustainable agriculture, as well as the interlinked targets of other Goals;

(PP6) Welcoming United Nations General Assembly resolution 70/259 of 1 April 2016, entitled “United Nations Decade of Action on Nutrition (2016–2025)”; which calls upon FAO and WHO to lead the implementation of the United Nations Decade of Action on Nutrition (2016–2025), in collaboration with the WFP, IFAD and UNICEF, and to identify and develop a work programme based on the Rome Declaration on Nutrition and its Framework for Action, along with its means of implementation for 2016–2025, using coordination mechanisms such as the Standing Committee on Nutrition and multistakeholder platforms such as the Committee on World Food Security, in line with its mandate, and in consultation with other international and regional organizations and platforms;

(PP7) Reaffirming the commitment to eradicate hunger and prevent all forms of malnutrition worldwide, particularly undernourishment, stunting, wasting, underweight and

¹ Document A69/7.

overweight in children under 5 years of age and anaemia in women and children, among other micronutrient deficiencies; as well as to reverse the rising trends in overweight and obesity and reduce the burden of diet-related noncommunicable diseases in all age groups;

(PP8) Recalling resolution WHA65.6 (2012), endorsing the comprehensive implementation plan on maternal, infant and young child nutrition;

(PP9) Expressing concern that nearly two in every three infants under 6 months are not exclusively breastfed; that fewer than one in five infants are breastfed for 12 months in high-income countries; and that only two in every three children between 6 months and 2 years of age receive any breast-milk in low- and middle-income countries;

(PP10) Expressing concern that only 49% of countries have adequate nutrition data to assess progress towards the global nutrition targets,

(OP1) CALLS UPON all relevant United Nations funds, programmes, specialized agencies, civil society and other stakeholders:

- (1) to work collectively across sectors and constituencies to guide, support, and implement nutrition policies, programmes, and plans under the umbrella of the United Nations Decade of Action on Nutrition (2016–2025);
- (2) to support mechanisms for monitoring and reporting of the commitments;

(OP2) URGES Member States:

- (1) to develop and/or implement strategies on maternal, infant and young child nutrition that comprehensively respond to nutrition challenges, span different sectors and include monitoring and evaluation;
- (2) to consider developing, when appropriate, policies and financial commitments that are specific, measurable, achievable, relevant and time-bound in respect of the voluntary options contained in the Framework for Action in the outcome document of the Second International Conference on Nutrition;
- (3) to consider developing, when appropriate, SMART policy and financial commitments related to the voluntary options contained in the ICN2 Framework for Action;
- (4) to report on their policy and investments for effective interventions to improve people's diets and nutrition, including in emergency situations;
- (5) to report on their policy to improve nutrition by strengthening human and institutional capacities to address all forms of malnutrition through, inter alia, relevant scientific and socioeconomic research and development, innovation and transfer of appropriate technologies on mutually agreed terms and conditions;

(OP3) REQUESTS the Director-General:

- (1) to work with the Director-General of FAO:
 - (a) to support Member States, upon request, in developing, strengthening and implementing their policies, programmes and plans to address the multiple challenges of malnutrition, and convene periodic meetings of inclusive nature to share best practices, including consideration of commitments that are specific, measurable, achievable, relevant and time-bound within the framework of the Decade of Action on Nutrition (2016–2025);
 - (b) to maintain an open access database of commitments for public accountability and include an analysis of the commitments made in the biennial reports on implementation of the outcome document of the Second International Conference on Nutrition and the Framework for Action;
- (2) to ensure that WHO stays fit for purpose to provide its technical support to Member States for the implementation of the Decade of Action on Nutrition;

- (3) to continue supporting the Breastfeeding Advocacy Initiative to increase political commitment to and investment in breastfeeding as the cornerstone of child nutrition, health and development;
- (4) to support national nutrition data collection.

The CHAIRMAN drew attention to another draft resolution, proposed by Ecuador, which read:

The Sixty-ninth World Health Assembly,

(PP1) Recalling resolutions WHA33.32 (1980), WHA34.22 (1981), WHA35.26 (1982), WHA37.30 (1984), WHA39.28 (1986), WHA41.11 (1988), WHA43.3 (1990), WHA45.34 (1992), WHA46.7 (1993), WHA47.5 (1994), WHA49.15 (1996), WHA54.2 (2001), WHA55.25 (2002), WHA58.32 (2005), WHA59.21 (2006), WHA61.20 (2008) and WHA63.23(2010) on infant and young child nutrition, appropriate feeding practices and related questions;

(PP2) Further recalling resolution WHA65.6 (2012) on maternal, infant and young child nutrition, in which the Health Assembly requested the Director-General to provide guidance on the inappropriate promotion of foods for infants and young children cited in resolution WHA63.23;

(PP3) Convinced that guidance on ending the inappropriate promotion of foods for infants and young children is needed for Member States, the private sector, health systems, civil society and international organizations,

(OP1) ENDORSES the technical guidance on ending the inappropriate promotion of foods for infants and young children;

(OP2) URGES Member States:^{1,2}

(OP2.a) to take all necessary measures to implement the guidance recommendations on ending the inappropriate promotion of foods for infants and young children, as a minimum requirement, while taking into account existing legislation and policies;

(OP2.b) to establish a system for monitoring, evaluating and, as appropriate to national context, enforcing the implementation of the guidance recommendations on ending the inappropriate promotion of foods for infants and young children;

(OP2.c) to implement the WHO set of recommendations on the marketing of foods and non-alcoholic beverages to children, and to adopt a comprehensive approach to implementation of those recommendations, including through legislation, and other types of regulations paying particular attention to ensuring that settings where infants and young children gather are free from all forms of marketing of foods that are high in saturated fats, trans-fatty acids, free sugars, or salt;

(OP3) CALLS UPON manufacturers and distributors of foods for infants and young children to end all forms of inappropriate promotion by fully implementing the recommendations set forth in the guidance on ending the inappropriate promotion of foods for infants and young children, irrespective of whether the recommendations have been transposed into national and/or regional legislation;

(OP4) CALLS UPON health care professionals to fulfil their essential role in providing parents and other caregivers with information and support on optimal infant and young child feeding practices, acknowledging specific individual nutritional needs of children,³ and to

¹ And, where applicable, regional economic integration organizations.

² Taking into account the context of federated states.

³ WHO/UNICEF. Acceptable medical reasons for use of breast-milk substitutes, WHO, 2009.

implement the recommendations set forth in the guidance on ending the inappropriate promotion of foods for infants and young children, irrespective of whether the recommendations have been transposed into national legislation;

(OP5) CALLS UPON the media and creative industries to ensure that their activities across all communication channels and media outlets, in all settings and using all marketing techniques comply with the recommendations set forth in the guidance on ending the inappropriate promotion of foods for infants and young children;

(OP6) CALLS UPON civil society to support ending inappropriate promotion of foods for infants and young children, including activities to advocate for, monitor and evaluate the implementation of the guidance recommendations;

(OP7) REQUESTS the Director-General:

(OP7.a) to provide technical support to Member States in implementing the guidance recommendations on ending the inappropriate promotion of foods for infants and young children and in monitoring and evaluating its implementation and impact on infant and young child nutrition;

(OP7.b) to review national experiences with implementing the guidance recommendations in order to build the evidence on its effectiveness and consider changes, if required;

(OP7.c) to assess the use and marketing impact of vitamin and mineral supplement and home fortification products, such as micronutrient powders and small quantity lipid-based nutrition supplements, and provide guidance on the inappropriate promotion of such products to the Seventy-first World Health Assembly in 2018 for its consideration;

(OP7.d) to strengthen international cooperation with United Nations organizations, most notably FAO, UNICEF and WFP, in promoting national implementation of the guidance on ending the inappropriate promotion of foods for infants and young children;

(OP7.e) to report on implementation of the guidance recommendations on ending the inappropriate promotion of foods for infants and young children as part of the report on progress in implementing the comprehensive implementation plan on maternal, infant and young child nutrition to the Seventy-first and Seventy-third World Health Assemblies in 2018 and 2020.

The representative of ECUADOR proposed that a drafting group should be established to carry out an in-depth discussion of the two draft resolutions. He suggested that the drafting group should meet at least four times before the further discussion of the agenda item by the Committee.

The representative of AUSTRALIA said that, although he supported the proposal to establish a drafting group to discuss the draft resolutions, he was disappointed that the first draft resolution, proposed by Ecuador and Peru, had been put forward and circulated so late. Moreover, having four drafting group sessions was excessive; agreement could be reached in less time.

The representative of SWEDEN said that, although he had no objection to the proposal to establish a drafting group, he was concerned about placing an additional burden on the Committee and on the Health Assembly, which were already struggling to address all the items on the agenda. He sought further clarification on the two draft resolutions, including the relationship between them, and wondered when delegations would have the time to study them before their discussion in the proposed drafting group.

The representative of MONGOLIA, outlining her country's progress in meeting the global targets relating to maternal, infant and young child nutrition and its measures to improve achievement,

requested continued support from international partners to address anaemia and micronutrient deficiencies in young children and women of reproductive age. She expressed support for the draft guidance on ending the inappropriate promotion of foods for infants and young children.

The CHAIRMAN took it that the Committee wished to establish a drafting group to discuss the two draft resolutions under item 12.1, to be chaired by the representative of Ecuador.

It was so agreed.

(For continuation of the discussion and approval of the draft resolutions, as well as information on the financial and administrative implications of the adoption of the draft resolutions for the Secretariat, see the summary record of the twelfth meeting, section 2.)

2. PROMOTING HEALTH THROUGH THE LIFE COURSE: Item 13 of the agenda

Monitoring of the achievement of the health-related Millennium Development Goals: Item 13.1 of the agenda (document A69/14)

Health in the 2030 Agenda for Sustainable Development: Item 13.2 of the agenda (documents A69/15 and EB138/2016/REC/1, resolution EB138.R5)

Mr Steele took the Chair.

The CHAIRMAN recalled that the Committee had agreed to consider items 13.1 and 13.2 of the agenda together.

The representative of the REPUBLIC OF KOREA, speaking in his capacity as a member of the Executive Board, recalled that, in January 2016, at its 138th session, the Executive Board had considered the Secretariat reports on the monitoring of the achievement of the health-related Millennium Development Goals and on health in the 2030 Agenda for Sustainable Development. In their discussions, Members had focused on the possible health implications of the 2030 Agenda, and had raised a wide range of issues. The Executive Board had discussed a draft resolution on health in the 2030 Agenda for Sustainable Development, which had been sponsored by several delegations, and, as agreed at that session, informal consultations were being held to prepare a revised version of that draft resolution.¹ He invited the Committee to approve the draft resolution contained in resolution EB138.R5 on strengthening essential public health functions in support of the achievement of universal health coverage.

The representative of the ISLAMIC REPUBLIC OF IRAN, speaking on behalf of the Member States of the Eastern Mediterranean Region, recalled that the Sustainable Development Goals were about development, and not just about developing countries. More innovative, inclusive, results-oriented and responsive health systems would be required to meet population health needs, taking into consideration the social determinants of health defined under the 2030 Agenda. Monitoring progress towards achieving the Sustainable Development Goals would require national technical capacity and strengthened health financing and information systems. Indicators should be developed in consultation with Member States and in line with existing global and regional indicators, which would be a

¹ See the summary records of the Executive Board at its 138th session, twelfth meeting, section 1 (document EB138/2016/REC/2).

complex process given the number of indicators required. Moreover, the legitimate concern for accountability may result in too many demands for data, meaning the 2030 Agenda might fail to gain support, particularly in countries already over-burdened by existing reporting requirements. WHO must play a lead role and offer an example to other sectors on how to operationalize the 2030 Agenda. Close collaboration between United Nations agencies and international organizations would be critical in providing the necessary support to Member States, in order to ensure that efforts were not duplicated or limited resources wasted. Civil society bodies and other relevant structures would also have an important role to play in supporting governments.

The representative of JAPAN, noting that accountability had been an important aspect of the Millennium Development Goals, highlighted the critical need for high-quality data at the country level and for WHO support in that area. WHO would play an important role in achieving the Sustainable Development Goals by enhancing collaboration and harmonization between partners and stakeholders. His Government remained committed to achieving universal health coverage and sharing its experiences and knowledge to improve health systems at the national and regional levels. He supported the draft resolution on universal health coverage, of which his country was a cosponsor, and the draft resolution on health in the 2030 Agenda that was currently the subject of informal consultations.

The representative of MEXICO said that health was an essential component of the 2030 Agenda, not least because of its impact on many of the targets and Goals in addition to Goal 3. His Government was committed to global action and to the continued strengthening of universal health coverage and an intersectoral approach to provide better health services to those most in need, in line with the overarching health Goal under the 2030 Agenda.

The representative of LEBANON said that the individual nature of the targets under the Millennium Development Goal had drawn fragmented and programme-specific development assistance, while the Sustainable Development Goals required a holistic approach to financing and management, as well as strengthened health governance. Strong health systems would be required if unmet Millennium Development Goals were to be attained, and to ensure progress towards universal health coverage and resilience against epidemic diseases and disasters. Prioritizing the 13 health-related targets under the 2030 Agenda at the national level was a major challenge because of their cross-cutting nature; however, encouraging countries to adopt a national list of indicators would help in that regard. She sought the Secretariat's assistance in maintaining and strengthening her own country's capacity to manage information, define a national list of indicators and build monitoring systems. The needs created by the ongoing situation in the Syrian Arab Republic and the resulting refugee crisis had to be addressed in order to enable continued progress towards attaining the Millennium Development Goals and Sustainable Development Goals. She endorsed the draft resolution on universal health coverage.

The representative of MONACO said that universal health coverage was fundamental to the 2030 Agenda and to achieving the Sustainable Development Goals and reiterated her country's commitment to those Goals, which were crucial for building robust and efficient health systems. WHO must take a leading role, in cooperation with other United Nations agencies and programmes, in providing Member States with guidance, strategies and technical support to help attainment of the Sustainable Development Goals and report regularly to the governing bodies. Her Government wished to be added to the list of cosponsors of the draft resolution on universal health coverage.

The representative of JAMAICA underscored the need to increase capacity for public health services, and to address the social determinants of health to achieve universal health coverage and the Sustainable Development Goals. Research had established that the family environment was the most important pillar and determinant of health and well-being throughout the life course, and that the

public health and social challenges faced by many countries resulted from fractured families, often characterized by absent fathers. Therefore, the central importance of the family in health, social well-being and development must be reflected in pro-family legislation, policies and programmes, cutting across all sectors and involving all stakeholders, if the Sustainable Development Goals were to be achieved.

The representative of EGYPT outlined the steps taken by her Government to attain Millennium Development Goals 4 and 5, improve nutrition for children and pregnant women, encourage breastfeeding and implement universal health coverage through a new health insurance law.

The representative of the CONGO said that, despite encouraging results with respect to HIV, progress still needed to be made in the area of maternal, neonatal and infant health. There were significant discrepancies in attainment between Member States as a result of weak health systems, insufficient vaccination coverage, prevalent malaria and an absence of universal health coverage. International partners should support national efforts towards policy-making and health system strengthening. He called on the Secretariat to evaluate periodically the implementation of the Sustainable Development Goals and to apply the lessons learned from monitoring the attainment of the Millennium Development Goals. He supported the draft resolution on universal health coverage.

The representative of IRAQ highlighted the importance of the full provision of primary health care, intersectoral collaboration, and community participation. National workplans, to include monitoring and evaluation, were required for the implementation of the Millennium Development Goals and the Sustainable Development Goals, with the support of WHO in collaboration with other international organizations. Efforts to implement the Sustainable Development Goals should be effective and pragmatic, and take into account local contexts and potential emergencies and disasters. Further work was needed in those areas where insufficient progress had been made in attaining the Millennium Development Goals.

The representative of SAUDI ARABIA, noting that progress in attaining the Millennium Development Goals had been uneven, drew attention in particular to the repercussions of conflict and emergency situations on the achievement of Goal 7, in respect of access to safe drinking water and basic sanitation. There was an urgent need for WHO to provide technical support and for effective coordination between United Nations agencies and all other relevant stakeholders. Political commitment was vital to ensure and facilitate the achievement of better health outcomes. Indeed, political commitment and financial resources were essential prerequisites for promoting the changes envisaged in the 2030 Agenda. There was also a need to support all Member States in their efforts to realign their strategic plans for the post-2015 period.

The representative of PAPUA NEW GUINEA said that while the targets under the Millennium Development Goals had been integrated into his country's national policies and plans, progress thus far had been mixed. However, the rollout of the national health service, free primary health care and the subsidized specialist care policy should improve access to quality health services, and the Government had taken steps to address gaps in the health workforce and health information gathering, and to develop universal health coverage. He supported the draft resolution on universal health coverage.

The representative of NORWAY stressed the need for strategic priority-setting in order for WHO to take a global leadership role in areas targeted by the Sustainable Development Goals, where it had comparative advantages in the global health architecture. WHO should set an example by working in a more integrated way on a wider range of issues. Measures aimed at health system strengthening needed to be prioritized in the light of the global burden of noncommunicable disease and mental health problems, demographic challenges and potential pandemics. He emphasized the

need to develop primary health care services, strengthen the health workforce, and monitor the quality of and access to health services. As the health-related Millennium Development Goals had not been accomplished in areas of crisis or conflict, he called on WHO to give guidance and use its leadership role to align humanitarian and long-term development efforts to facilitate access to universal health coverage.

The representative of SURINAME recalled that, while the Millennium Development Goals had not been fully met, the focus on measurement had encouraged governments to achieve specific targets and improve accountability. By accelerating social, economic and environmental action, and building on lessons learned and best practices from efforts to attain the Millennium Development Goals, the 2030 Agenda could provide a more realistic and sustainable future for all.

The representative of MONGOLIA outlined the steps her Government had taken towards development planning and financing. Development cooperation remained vital for the implementation of the 2030 Agenda. Monitoring and evaluation systems needed to be further strengthened to measure the impact of government policies, programmes and projects and contribute to results-based governance. Expressing her Government's commitment to the 2030 Agenda, she emphasized that domestic and international public resources should be utilized for long-term investments in sustainable development, which would prove challenging for countries like her own, which were facing financial constraints and decreasing funding from international organizations. She called on WHO to reaffirm its commitment to focus on poor populations, including in middle-income countries, as scaling back development assistance would put them at risk and jeopardize progress towards the equitable attainment of the Sustainable Development Goals.

The representative of AUSTRALIA welcomed the recognition of small island developing States in the 2030 Agenda. Moreover, she supported the draft resolution on universal health coverage, and looked forward to the circulation of the draft resolution on health in the 2030 Agenda, as both reflected her country's priorities. Acknowledging the need to develop all sources of funding for health outcomes, she encouraged WHO to leverage the comparative advantage of other United Nations agencies and development banks, and promote diverse partnerships within the public and private sectors. It was essential that WHO's priorities and finances should be aligned to the 2030 Agenda, and she asked the Secretariat how it proposed to facilitate discussion in that regard when planning for the thirteenth general programme of work, 2020–2025. She called on WHO to support the review process for the 2030 Agenda and the further refining of indicators, and encouraged cooperation with other United Nations bodies. WHO had an important role to play in providing support to developing countries in the area of data collection. Furthermore, it should proactively seek to shape the global health architecture at all levels, including measuring the effectiveness of health governance.

The representative of CANADA said that overcoming persistent inequalities, addressing the determinants of health for the poorest and most disadvantaged populations and improving measurement and accountability were crucial for the achievement of the Sustainable Development Goals. Welcoming the importance attached to sexual and reproductive health and rights, she reiterated her Government's focus on providing international assistance in respect of the empowerment of women and girls and the protection and promotion of their rights. Given the linkages between environment and human health, she urged the health sector to scale up related activities and encouraged the Secretariat to support Member States' efforts to meet the health-related Goals and promote multisectoral collaboration at the global and country levels, and within the Organization. She supported the draft resolution on universal health coverage and indicated that her country wished to be added to the list of cosponsors of the draft resolution on health in the 2030 Agenda for Sustainable Development that was currently being prepared.

The representative of SRI LANKA said that the increased burden of noncommunicable diseases was a major obstacle for his country's move towards universal health coverage, and a national action plan for the prevention and control of noncommunicable diseases would strengthen the health system and primary health care institutions in that regard and included actions to promote lifestyle changes. At the global level, improving health required strong and sustained political commitment, increased investment and more affordable technology. WHO must play a key role in the implementation of the 2030 Agenda. He supported the draft resolution on universal health coverage.

The representative of BAHRAIN said that his country had attained all the health-related Millennium Development Goals. In addition, it had contributed to the development of the Sustainable Development Goals, including by hosting the Second Session of the Arab High-level Forum on Sustainable Development in May 2015, and had integrated the Sustainable Development Goals into national plans and strategies. The Secretariat should continue to support Member States in the implementation and monitoring of the health-related Sustainable Development Goals.

The representative of the UNITED REPUBLIC OF TANZANIA said that the framework for the attainment of the Sustainable Development Goals provided useful guidance for Member States. In order to address the challenges affecting the health system, his country would implement the Health Sector Strategic Plan 2015–2020; develop a financing strategy to facilitate the attainment of universal health coverage; and operationalize a five-year health sector monitoring and evaluation plan. Building commitment to the Sustainable Development Goals required political will and regional and international collaboration; he supported the adoption of the relevant draft resolutions.

The representative of the NETHERLANDS spoke on behalf of the European Union and its Member States. The candidate countries Turkey, the former Yugoslav Republic of Macedonia and Serbia, the country of the Stabilization and Association Process and potential candidate Bosnia and Herzegovina, as well as Ukraine and Georgia, aligned themselves with the statement. She welcomed the ongoing discussions on the draft resolution on health in the 2030 Agenda for Sustainable Development. Health-related matters must be addressed directly through Sustainable Development Goal 3 and determinants of health embedded in the other Goals. Measures taken in the context of WHO reform should be aligned with the 2030 Agenda. The Organization should work in a more integrated and multisectoral way in order to facilitate timely and effective delivery of the health-related Sustainable Development Goals. It should enhance its leading role in the Global Health Cluster and the wider United Nations system, and strengthen global, regional and national efforts towards sustainable development through its normative and technical work.

The representative of FINLAND said that the Sustainable Development Goals had lent new legitimacy to efforts to address the wider determinants of health. WHO must provide global leadership, normative guidance and technical support for the achievement of the health-related Goals, in particular universal health coverage. In order to achieve that, sustainable funding, social protection and essential public health functions were vital. Health promotion and disease-burden reduction at the population level must also be a priority. She invited Member States to adopt the draft resolution on universal health coverage that had been proposed by her delegation.

The representative of BELGIUM said that the multisectoral nature of the Sustainable Development Goals should not be seen as an invitation to mobilize the widest possible range of actors to individually address the largest possible range of Goals at the same time. The health-related targets should not be seen as distinct, as they all reflected the same need, namely for strong, broadly accessible, people-centred health systems. The role of WHO in the implementation of the Sustainable Development Goals must be clearly defined, identifying priorities. Such clarity could encourage donors, help assess the attainment of health-related Goals, and guide the work of the Organization, both internally and with regard to its external partners.

The representative of the REPUBLIC OF KOREA said that sustainable, innovative and effective international collaboration was needed to advance the health-related targets of the Sustainable Development Goals, drawing on the lessons learned from the implementation of the Millennium Development Goals. She therefore supported the draft resolution on universal health coverage. Achievement of universal health coverage required consistent international action, multisectoral cooperation under WHO leadership, and information-sharing at all levels. Clear national targets and assessment indicators were crucial to ensuring the active engagement of Member States.

The representative of INDONESIA supported the draft resolution on universal health coverage. The 2030 Agenda for Sustainable Development attributed common, but different, responsibilities to States. Local policies, priorities, capacities and aspirations must be identified, and regional forums used as strategic platforms for sharing information, lessons, ideas and technical assistance. Investments must be used efficiently, produce visible outcomes and support national development. Her Government had taken measures to strengthen its health system noting that health workforce distribution, capacity building and the implementation of national health insurance were key concerns. The quality of public health data should be improved through multisectoral collaboration, which would facilitate better monitoring.

The representative of the PHILIPPINES said that her country had not fully achieved all the health-related Millennium Development Goals. The adoption of the 2030 Agenda presented the challenge of moving on from pursuing attainment of the Millennium Development Goals. Targets and indicators should be streamlined to enable more accurate, effective and efficient data collection and analysis. The information management infrastructure should be improved, including by supporting capacity building on data processing. The health-related Sustainable Development Goals provided an opportunity for WHO to demonstrate its leadership, by facilitating partnerships and capacity building, with a focus on the social determinants of health.

The representative of ZIMBABWE said that the 2030 Agenda represented a paradigm shift by recognizing that all countries were responsible for development. Despite progress on the Millennium Development Goals, much remained to be done. Health systems must be strengthened, revitalizing the primary health care approach, in order to address emerging threats and priorities in a holistic manner. WHO country and regional offices should play a vital role in assisting countries during the transition to the 2030 Agenda. Predictable and reliable financing was essential. An increase in WHO assessed contributions in the forthcoming biennium, and innovative domestic financing for health, would be useful. A holistic, horizontal approach was needed to strengthen national health systems, with well-coordinated support from international partners, in order to achieve universal health coverage. She recalled that her country had been added to the list of cosponsors of the draft resolution on universal health coverage.

The representative of JORDAN said that his country had worked hard towards achieving the health-related Millennium Development Goals, especially in the area of maternal and child mortality. It had strengthened its health system and trained health workers in the use of clinical protocols, among other things. However, mass influx of refugees from the Syrian Arab Republic had placed a heavy burden on the health sector and had slowed down progress. Challenges included the high prevalence of tuberculosis and hepatitis A in refugee camps and the cost and difficulty of providing food and, in particular, water for refugees. He invited WHO to help his country with the vaccination of refugees in order to improve the health situation in camps.

The representative of CHINA described the progress made in his country to achieve the Millennium Development Goals and his Government's plans for health promotion in line with the Health in All Policies approach. The Secretariat should summarize Member States' experiences and lessons learned, provide further technical assistance and promote the role of health-related targets

under the 2030 Agenda for Sustainable Development. His country remained committed to cooperating with international organizations and other Member States in the field of health.

The representative of GERMANY noted that universal health coverage cut across all the health-related targets of the 2030 Agenda and that strong health systems were key to achieving universal health coverage. He advocated coordinated global efforts to strengthen health systems and establish comprehensive systems to protect individuals from the financial risks associated with ill health. In that regard, in collaboration with WHO, his country had launched the development of a road map for the Healthy Systems – Healthy Lives initiative, aimed at strengthening health systems.

The representative of THAILAND said that health system constraints and a lack of commitment and implementation capacity were the main barriers to ensuring access to quality health services in countries that had not achieved all the Millennium Development Goals. Greater efforts were needed to achieve the more ambitious Sustainable Development Goals, with particular regard to intersectoral action on non-health sector determinants of health; and efforts should sustain gains made and draw on the lessons learned from the Millennium Development Goals. Global monitoring was essential to accelerating progress towards the Sustainable Development Goals, and indicators for universal health coverage must include an indicator on financial risk protection. He supported the draft resolution on universal health coverage and the draft resolution on the 2030 Agenda that was currently being prepared.

The representative of the FEDERATED STATES OF MICRONESIA said that he looked forward to developing further partnerships to achieve the Sustainable Development Goals and expressed support for the health-related targets of the 2030 Agenda. He supported the draft resolution on universal health coverage and counted on the Organization's support for its implementation.

The representative of SWITZERLAND noted that, while universal health coverage was a crucial target, it should not be considered a substitute for Sustainable Development Goal 3, which was part of a set of integrated and indivisible Goals. The Organization should take on a leadership role to combat the risks of fragmentation and the multiplication of uncoordinated initiatives in the area of health and well-being, and should advocate a holistic approach to health and its determinants, bolstering its legitimacy in order to intervene in other sectors. That would require a review of competencies, internal reorganization, the allocation of resources and adequate operational and financial flexibility. The Secretariat should provide Member States with the support they needed to achieve Sustainable Development Goal 3. Strengthened efforts were needed to promote equality of access to health resources, and ensure that monitoring took into account geographical and socioeconomic variables. He supported the draft resolution on universal health coverage and the draft resolution on the 2030 Agenda that was currently being prepared. He proposed that the Director-General should prepare a joint report on the implementation of the two resolutions, in line with the planned reporting mechanism under the Sustainable Development Goals.

The representative of BRAZIL noted that, while it was important not to lose sight of the unattained targets under the Millennium Development Goals, the 2030 Agenda with its interlinked and indivisible Goals and targets had to be unequivocally embraced as a platform for the United Nations system as a whole. The Secretariat should support system-wide efforts to attain the Sustainable Development Goals, and provide particular support in respect of primary health care and the availability of trained health workers. Universal access to medicines and health treatment was critical, and support should be offered for innovative mechanisms and funding for research and development; WHO should play a guiding role in that regard. The double burden of noncommunicable diseases and unmet health needs faced by developing countries should be recognized. It would be essential to mobilize public and private resources to achieve the Sustainable Development Goals. WHO should focus in particular on Goal 17 (Revitalize the global partnership for sustainable development), and on

the means of attaining the other Goals, including target 3.b. The Secretariat should support the technology facilitation mechanism adopted under the 2030 Agenda and the Addis Ababa Action Agenda of the Third International Conference on Financing for Development.

The representative of ICELAND, noting that disorders and injuries of the central nervous system were a leading cause of disability, emphasized the importance of increasing knowledge in that area. The universal nature of the Sustainable Development Goals required Member States' participation at national, regional and global levels. He supported the draft resolution on universal health coverage, but would have preferred the inclusion, in the last sentence, of a reference to a time frame within which the Director-General should report to the Health Assembly.

The representative of ARGENTINA expressed his satisfaction that the 2030 Agenda contained a target on universal health coverage and included health as a major factor in the attainment of all Sustainable Development Goals. Reducing fragmentation and ensuring accountability were of importance; and the health-related indicators under the 2030 Agenda would highlight links between the Goals. Achievement of the Goals would depend on WHO's capacity to strengthen links within the health sector and expand its activities with other sectors. WHO's priorities and financing should be aligned with the 2030 Agenda, and options should be considered to facilitate reporting at the national, regional and global levels.

The representative of the RUSSIAN FEDERATION agreed that broad participation from WHO at the global, regional and country levels was required to achieve the Sustainable Development Goals. The Twelfth General Programme of Work, 2014–2019 allowed the Secretariat to provide coordination and technical assistance to help countries develop their national health systems. He expressed support for the Sustainable Development Goals and noted that Goal 3 was a national priority in his country, where a developed primary health care network had contributed to increased life expectancy. He supported the adoption of the draft resolution on universal health coverage.

The representative of ETHIOPIA expressed support for the draft resolution on universal health coverage, which would help to sustain the results of the Millennium Development Goals and achieve the 2030 Agenda. He described the efforts made in that regard in his country, which included a five-year plan to transform the health sector. He urged the development of health-related indicators and a monitoring and evaluation framework that took into account enhanced country ownership and alignment towards a single planning, monitoring and reporting system. He urged the Secretariat to provide technical and financial support to help countries achieve Sustainable Development Goal 3.

The representative of SENEGAL described the progress made in her country towards achieving the health-related Millennium Development Goals, including reduced infant and child mortality. Attainment of the Sustainable Development Goals provided an opportunity to build on the lessons learned during the previous 15 years.

The representative of PARAGUAY encouraged broad participation in the preparation of sustainable development strategies, which took into account different country situations and the multisectoral impact of health. More effective planning of health programmes and policies would ensure the attainment of the Sustainable Development Goals. She supported the draft resolution on universal health coverage.

The representative of TUNISIA said that health reforms in her country sought to reduce regional disparities and improve access to health care and medicines. Health promotion and prevention was at the core of a national five-year plan on health reform, the implementation of which would require WHO support. She supported the draft resolution on universal health coverage.

The representative of NAMIBIA drew attention to the linkage between Goal 3 and the other Sustainable Development Goals. The 2030 Agenda lent itself to a multisectoral approach to health and the use of technologies to build coherent health systems. The health-related targets demanded strategic interventions that were results-oriented, focused, high-impact and efficient. Given the lack of resources, innovative approaches to developing health care, especially for the most vulnerable, should be identified. In that regard, he welcomed the Addis Ababa Action Agenda of the Third International Conference on Financing for Development to support implementation of the 2030 Agenda. He underlined the need for WHO assistance for Member States in the fields of research, innovation and technology to achieve health outcomes. He supported the draft resolution on universal health coverage.

The representative of ALGERIA highlighted the importance of reducing inequalities within and among countries to achieve the Sustainable Development Goals. In that connection, the main objective of WHO should be the provision of technical assistance for the implementation of national plans. The allocation of financial resources would be a decisive factor, especially given the limited development budgets of many countries. Non-financial resources should also be mobilized, including knowledge transfer, innovation, and new technologies.

The representative of NEW ZEALAND supported the statement made by the representative of Jamaica regarding the need to prioritize the family environment for the achievement of better health outcomes. That focus on family units and communities was crucial to improve health outcomes related to family violence, child abuse, child obesity and maternal well-being; and programmes and policies supporting women, children, families and communities were of importance.

The representative of CHILE said that the Sustainable Development Goals offered an opportunity for WHO and other United Nations bodies to develop global health financing, strengthen cross-border health security, address the causes of noncommunicable diseases and strengthen accountability. The Sustainable Development Goals constituted an integrated framework of universally-applicable objectives that emphasized equity while respecting national sovereignty and taking into account local contexts. Health system strengthening was crucial, and universal health coverage would facilitate the attainment of other health-related Goals. Measurement systems should be improved to ensure comprehensive monitoring of progress. She strongly supported the Health in All Policies approach, which she hoped would drive the 2030 Agenda.

The representative of BARBADOS highlighted the importance of addressing noncommunicable diseases and the social determinants of health, as part of the 2030 Agenda. He urged the Secretariat to work with countries to examine alternative health financing models which would ensure quality health care based on the principles of equity, solidarity and social justice. WHO should cooperate closely with PAHO to develop monitoring and evaluation mechanisms and technical support, particularly for small island States in the Caribbean region. He supported the draft resolution on universal health coverage.

The representative of SOUTH AFRICA, speaking on behalf of the Member States of the African Region, said that the international community should ensure that health plans, resource allocation, and the organization of national health ministries contributed to the achievement of the Sustainable Development Goals. He called on the Director-General to report at the Seventieth World Health Assembly on progress made in respect of reorganization within WHO to facilitate the achievement of the Goals, and proposed that a reference thereto be included in the draft resolution on universal health coverage contained in resolution EB138.R5. It was vital to take into account the lessons learned from the Millennium Development Goals when planning the attainment of the Sustainable Development Goals, which also required political commitment. Through comprehensive intersectoral action, the social and economic factors underpinning health outcomes could be addressed.

He called on the Director-General to demonstrate leadership in the drive to realize the health-related Sustainable Development Goals. Innovative resources to facilitate progress should be identified and Member States should also reconsider increasing assessed contributions to enable WHO to support actions relating to the 2030 Agenda. Allocating adequate human and financial resources in regional and country offices, and securing WHO technical support, was also fundamental. He supported the draft resolution on universal health coverage.

The representative of PANAMA recalled that political contexts, economic instability, migration and budget allocations had a bearing on the achievement of the Sustainable Development Goals. The targets related to mental and environmental health represented significant challenges under Goal 3. Strong health systems, as well as interagency and intersectoral cooperation and civil society participation, were pivotal to the success of the 2030 Agenda. She urged WHO to continue providing Member States with technical and financial support. Efforts to attain the Sustainable Development Goals would require consideration of, inter alia, cost-effective strategies to monitor the impact of hazardous chemicals and pollution, and investment in health promotion and disease prevention. Her country was committed to the 2030 Agenda, and supported the draft resolution on universal health coverage, of which it was a cosponsor.

The representative of COLOMBIA welcomed the focus on research and innovation under the Sustainable Development Goals, with particular regard to research on health policies and systems, and she therefore encouraged the transfer of technology and knowledge. Coordination of support to Member States posed a challenge to the Organization in terms of improving its internal coordination of activities and the need to adapt approaches to each country's situation. It was also important to facilitate the mobilization of financial and non-financial resources at all levels. She urged WHO to work closely with the United Nations system and to strengthen interagency cooperation.

The representative of BHUTAN welcomed the 2030 Agenda, which prioritized sustainability and equitable human development. Achieving Sustainable Development Goal 3 would be possible only if progress was made in meeting the other targets. A great responsibility had been placed on WHO and its Member States to ensure that health was incorporated into all policies. Achieving universal health coverage and financing health actions proved a notable challenge, particularly for small countries like Bhutan. Greater emphasis should be placed on developing inclusive plans and ensuring that measurement and accountability mechanisms were in place. She called on WHO and other partners to support Member States in resource mobilization. She expressed support for the draft resolution on universal health coverage.

The representative of the DEMOCRATIC REPUBLIC OF THE CONGO said that Member States needed to work together to design integrated strategic plans and mobilize resources for the attainment of the Sustainable Development Goals. WHO should continue its leadership role in facilitating cooperation, particularly in resource mobilization, among and within countries to ensure intersectoral collaboration. He supported the draft resolution on universal health coverage.

The meeting rose at 11:45.

THIRD MEETING

Tuesday, 24 May 2015, at 14:45

Chairman: Mr M. BOWLES (Australia)

PROMOTING HEALTH THROUGH THE LIFE COURSE: Item 13 of the agenda (continued)

Monitoring of the achievement of the health-related Millennium Development Goals: Item 13.1 of the agenda (document A69/14) (continued)

Health in the 2030 Agenda for Sustainable Development: Item 13.2 of the agenda (documents A69/15, EB138/2016/REC/1, resolution EB138.R5) (continued from the second meeting, section 2)

The representative of TURKEY said that Millennium Development Goals and Sustainable Development Goals had guided Turkey's health transformation programme. Implementation of the global indicators framework would be essential in order to complete the work of the Millennium Development Goals and the improved health conditions and closer cooperation realized to date would be augmented further by finding ambitious ways of achieving universal health coverage. She supported continuation of reporting and data sharing through the follow-up and review mechanism. Provision of essential medicines in developing countries, intellectual property rights issues and the pricing of medicines were obstacles to achieving the Goals.

The representative of the UNITED STATES OF AMERICA welcomed efforts to align the work of WHO with the health targets of the Sustainable Development Goals and urged the Organization to support completion and implementation of the global reporting mechanism. The role of WHO in "governance for health" should be further defined since the parameters in the context of the revised global indicators framework remained unclear. Stronger collaboration between WHO and its global partners should be the primary strategy used to push forward policy issues. His delegation had worked closely with others in formulating the draft resolution on universal health coverage and stood ready to resolve any remaining concerns on the compromise text.

The representative of the DOMINICAN REPUBLIC said that a comprehensive approach would be needed to attain the Sustainable Development Goals. To that end, the Dominican Republic had implemented social and economic policies to encourage sustainable economic growth, fair distribution of wealth and poverty reduction, while promoting universal education, integrated health care, nutrition and food security. Effective epidemiological management and early warning and rapid response systems were crucial to meet the goals of lower health costs, improved quality of care and decreased malpractice. He endorsed the draft resolution on universal health coverage.

The representative of CHAD said that the challenges experienced in implementing the Millennium Development Goals, including the need for a coherent programme that took into account the social determinants relating to economic and environmental factors, should be considered when implementing the Sustainable Development Goals. It would be helpful for Member States to receive a clear definition of the targets and a schedule of deadlines up to 2030. Regional peer review workshops, with technical support from WHO, would allow Member States to consolidate their programmes and minimize delays in implementation.

The representative of BANGLADESH said that the Sustainable Development Goals placed emphasis on reducing inequities among and within countries and care should be taken not to rely on averages. WHO and its international partners needed to create new models to ensure the effective implementation and monitoring of the new Goals. Technical assistance provided by WHO would be instrumental in helping governments to strengthen health systems and make progress towards universal health coverage. The Ministry of Health and Family Welfare of Bangladesh had created an eHealth infrastructure that would enable reporting on the progress made towards the Goals in real time. His Government was committed to achieving the Goals, with continued technical support from WHO. He endorsed the draft resolution on universal health coverage.

The representative of NIGERIA said that it would be important to establish sustainable financing of the Sustainable Development Goals and to measure their implementation in order to ensure accountability. Indicators related to data and information management systems, including the key indicator of access to quality essential medicines, would be critical for evaluating the Goals. Efforts to achieve universal health coverage were under way in Nigeria and 10 000 primary health-care facilities would be strengthened over the coming two years.

The representative of the MALDIVES said that, although most Member States in the South-East Asia Region had made strides towards the Millennium Development Goals, significant disparities persisted within Member States. WHO should address the need for more integrated ways of working, as achieving Sustainable Development Goal 3 on good health and well-being was tied to progress made towards other Goals. Furthermore, reporting on the Sustainable Development Goals would involve more work than reporting on the Millennium Development Goals. Therefore, WHO should support national target-setting exercises and strengthen national health systems. National information systems and accountability mechanisms should be used to report on the ground covered. Financing would be a challenge for Member States, requiring the support of WHO and other key partners to mobilize resources.

The representative of NEPAL said that the role of WHO should be redefined to move forward the health agenda of the Sustainable Development Goals at all levels and across all sectors. That would require strengthening WHO capacity in order to mainstream and contextualize a health-related sustainable development agenda. As intersectoral engagement was required to achieve the Goals, a multisectoral coordination mechanism should be developed to harmonize and synthesize information and decision making.

The representative of URUGUAY outlined the progress made towards meeting the Millennium Development Goals in Uruguay, in particular those related to poverty reduction and maternal and child mortality. Efforts were being made to improve the health situation by reducing inequalities in access to health. Strategic objectives had been set, aimed at promoting healthy lifestyles and lowering the risk of noncommunicable diseases.

The representative of TOGO said that the Organization should provide technical assistance for the achievement of the Sustainable Development Goals through targeted interventions to improve the information management capacity of countries, facilitate knowledge sharing and national cooperation mechanisms, and develop new ways of promoting intersectoral partnerships.

The representative of FRANCE said that the intersectoral approach required to achieve the Sustainable Development Goals presented a challenge for WHO in the international sphere, as well as for ministers of health at the national level. Therefore, the Organization should position itself to be able to intervene in other sectors. In that respect, WHO should diversify the range of organizations with which it worked directly. In addition, health issues should be incorporated into the actions of a wide range of international organizations and financial institutions. Working with non-State actors

would be more necessary than ever to implement the health policies of WHO and Member States, and increase their capacity to act. A conference on strengthening intersectoral action for health in the European Region would be held in Paris later in 2016.

The representative of the BAHAMAS said that the shortfalls of the Millennium Development Goals should be retooled as strengths when implementing the Sustainable Development Goals. The achievement of the targets under the Sustainable Development Goals hinged on the capacity of individual countries to collect data and monitor and evaluate the Goals. WHO's influence with governments and donors must be leveraged to ensure that health financing structures were directed towards supportive and preventive measures so that the long-term and upstream result of reduced needs for curative and palliative care could be achieved.

The representative of UNFPA said that further collaboration was required to achieve Millennium Development Goal 5 on improving maternal health. Regarding Sustainable Development Goal 3 on ensuring healthy lives and promoting well-being for all at all ages, it was paramount to guarantee universal access to sexual and reproductive health services as part of universal health coverage. Prevention should be an integral component of those services. Adolescents who were covered by their parents' health insurance should be able to access confidential sexual and reproductive health services without parental permission. Investment in human resources for health care was essential to ensure functional, robust and resilient health systems.

The observer of CHINESE TAIPEI outlined some of the achievements made in Chinese Taipei with respect to universal access to reproductive health services, the Health in All Policies approach and the Sustainable Development Goals, which included a reduction of the adolescent fertility rate and a decline in the prevalence of obesity. Concerning the Sustainable Development Goal indicators, she called for the meaningful and effective use of data, and public reporting of progress with relevant comparisons and public communication through scientific journals and press releases. Relevant benchmarking and ranking were necessary to maintain global political momentum and external support could be provided for those that found it difficult to make progress. Strengthening surveillance systems, including capacity building and provision of technical and financial support, was a matter of urgency.

The observer of the INTERNATIONAL FEDERATION OF RED CROSS AND RED CRESCENT SOCIETIES said that countries should prioritize humanitarian and fragile settings when undertaking commitments relating to the Sustainable Development Goals and developing universal health coverage plans. Experience had shown that communities living in such settings were resourceful and could significantly contribute to reducing mortality rates when empowered and provided with essential commodities and training.

The representative of the INTERNATIONAL LACTATION CONSULTANT ASSOCIATION, speaking at the invitation of the CHAIRMAN, welcomed the report on the monitoring of the achievement of the health-related Millennium Development Goals, noting that the current momentum needed to be maintained. The issue of deaths among children under 5 years of age due to undernutrition should be addressed urgently as part of Millennium Development Goal 4 on reducing child mortality. It was vital for WHO to strengthen the International Code of Marketing of Breast-Milk Substitutes.

The representative of the GLOBAL HEALTH COUNCIL, speaking at the invitation of the CHAIRMAN, said that, in order to achieve the Sustainable Development Goals, it was crucial to provide for the right to health. Member States should therefore seriously consider the proposed framework convention on global health. The Director-General should establish a working group, with strong civil society participation, to examine and report back on the potential benefits, principles and

parameters of the framework, and the Health Assembly and Executive Board should take swift action on the process.

The representative of the INTERNATIONAL ALLIANCE OF PATIENTS' ORGANIZATIONS, speaking at the invitation of the CHAIRMAN, stressed the need to accelerate the achievement of target 3.8 under Sustainable Development Goal 3, which gave Member States a golden opportunity to work together to create patient-centred health systems worldwide. He endorsed the recommendation that the Health Assembly adopt the draft resolution contained in EB138.R5.

The representative of the INTERNATIONAL COUNCIL OF NURSES, speaking at the invitation of the CHAIRMAN, said that the role of nursing in achieving the Sustainable Development Goals was of the utmost importance. The work on Goal 3 should be connected with that on many other Goals. System-wide investment in universal health care, with a focus on health promotion and prevention of illness, was also essential. WHO and governments should continue to involve nurses actively in planning and decision-making on all relevant policies and strategies.

The representative of MEDICUS MUNDI INTERNATIONAL – INTERNATIONAL ORGANISATION FOR COOPERATION IN HEALTH CARE, speaking at the invitation of the CHAIRMAN, highlighted the importance of selecting drivers in respect of Sustainable Development Goal 12 on responsible consumption and production that would compel all actors to contribute to changing unsustainable consumption and production patterns. Goal 8 on decent work and economic growth, and Goal 17 on partnerships for the goals, were of particular concern, as they suggested that social development could be maintained using the same economic policies that had caused global ecological and financial crises, and that all countries would benefit equally from free trade regimes. The strategies addressing unfair trade, unstable finances, global tax and investment regimes and intellectual property laws needed to be credible. For the least developed countries to achieve the Sustainable Development Goals, debt relief other than debt financing should be a key strategy. A more coherent plan, which should not be based on even higher levels of economic liberalization and free trade, was needed to address equity concerns.

The representative of OXFAM, speaking at the invitation of the CHAIRMAN, expressed concern that some countries had reintroduced health-care user fees and urged ministers to seek other options for financing health care. Donors should help to provide free health care for countries that had had to resort to fees. Health ministers should call for Sustainable Development Goal indicator 3.8.2, on out-of-pocket health expenditure, to be changed, as it risked dictating the path for countries to take to obtain universal health coverage. She supported the indicator proposed by WHO: measuring financial barriers and ensuring their removal was key to achieving universal health coverage.

The representative of THE SAVE THE CHILDREN FUND, speaking at the invitation of the CHAIRMAN, said that the focus on health systems in the 2030 Agenda should include individual health security. Political commitment was needed for progress to be made and universal health coverage strategies should prioritize groups that were left behind. Reproductive, maternal, newborn, child and adolescent services should be a priority and be available free of charge at the point of use in every community. To increase investment in public services, national tax systems should be made more efficient and tax evasion and illicit financial flows must be addressed at the global level. The prices of vaccines and medicines should be lowered. Coverage of services and financial protection should be tracked through the right indicators, and accountability mechanisms for universal health coverage were required at all levels.

The representative of the WORLD MEDICAL ASSOCIATION, INC., speaking at the invitation of the CHAIRMAN, welcomed the resolution and agreed that the 2030 Agenda could not be achieved without proper funding, an effective monitoring system and true health governance. It was

important to tackle the unfinished business of the Millennium Development Goals in the area of health, but that could not be done without addressing the social determinants of health. The role of physicians, especially primary care doctors, in health promotion, disease prevention and health security, was also crucial. While she appreciated efforts to revisit current WHO priorities, align budgeting and finance with the new agenda and enhance capacity building, knowledge transfer and technical support, further intersectoral collaboration would be necessary to reach the Goals and targets of the 2030 Agenda.

The representative of the WORLD FEDERATION OF PUBLIC HEALTH ASSOCIATIONS, speaking at the invitation of the CHAIRMAN, said that public health systems were often fragmented, variable and incomplete. Therefore, his federation had developed a Global Charter for the Public's Health, in line with the Sustainable Development Goals, which included succinct and practical implementation guidelines allowing public health associations to work with other nongovernmental organizations, training and research institutions, civil society and governments to improve the planning and implementation of health strategies across the globe. He called on the Director-General to adopt a WHO action plan on public health based on that charter.

The representative of the WORLD HEART FEDERATION, speaking at the invitation of the CHAIRMAN, called on Member States to promote a Health in All Policies approach and ensure policy coherence across the 2030 Agenda for Sustainable Development. It was also necessary to agree on a robust and comprehensive follow-up and review framework that would ensure accountability at all levels, support progress and address challenges. Indicators for progress must be aligned with existing indicators such as those in the global monitoring framework for the prevention and control of noncommunicable diseases. In addition, Member States should deliver on the commitments made in the Addis Ababa Action Agenda of the Third Conference on Financing for Development, including the commitment to increase domestic resource mobilization. They should also promote meaningful engagement of civil society at all levels of implementation.

The representative of the WORLD ORGANIZATION OF FAMILY DOCTORS, speaking at the invitation of the CHAIRMAN, said that primary care teams worldwide contributed greatly to progress towards the Sustainable Development Goals. As a result, national governments needed to be ambitious in measuring progress towards strengthening primary health care. Indicators used should be based on principles such as equity, community participation and prevention. Monitoring activities should measure the elements that made primary health care services successful, including comprehensiveness, coordination and person-centred care. Health financing indicators should track government expenditure on primary care and provide information on the economic accessibility of primary care services. Indicators on the make-up and distribution of the primary care workforce were also crucial.

The representative of the INTERNATIONAL PLANNED PARENTHOOD FEDERATION, speaking at the invitation of the CHAIRMAN, noted with concern that target 3.8 of Sustainable Development Goal 3, on universal health coverage, was given more prominence in the report than all others, although it had originally been considered on a par with other targets. Indeed, some targets required programmatic interventions that went beyond universal health coverage. For instance target 3.3 on ending HIV/AIDS required outreach programmes that tackled stigma and discrimination. Furthermore, if the United Nations high-level political forum on sustainable development was to play a primary role in overseeing the follow-up and review process of the 2030 Agenda, it must forge strong links with the Health Assembly and all health targets must be part of the overall implementation, follow-up and review process. There should also be an effective, integrated data collection process with an emphasis on data disaggregation, especially for vulnerable and marginalized groups.

The representative of the INTERNATIONAL FEDERATION OF MEDICAL STUDENTS' ASSOCIATIONS, speaking at the invitation of the CHAIRMAN, said that civil society involvement and intersectoral collaboration were key to achieving the Sustainable Development Goals. The involvement of young people was also vital, since they would be the driving force behind the 2030 Agenda. WHO should, therefore, forge stronger partnerships with youth-led organizations. A rights-based approach to sustainable development with people-centred policies, such as a commitment to universal health coverage, was equally important. The International Federation of Medical Students' Associations was fully committed to the implementation of the 2030 Agenda and called for stronger collaboration between all stakeholders and solid governance.

The representative of WORLD VISION INTERNATIONAL, speaking at the invitation of the CHAIRMAN, affirmed the importance of leadership in health governance to achieve the health targets of the 2030 Agenda including universal health coverage. In his report to the 2016 United Nations General Assembly High-Level Meeting on Ending AIDS, the United Nations Secretary-General had encouraged the international community to consider a comprehensive framework convention on global health which would establish standards, processes and mechanisms of health governance. She urged the Director-General and Member States to commence negotiations for such a convention.

The representative of WATERAID, speaking at the invitation of the CHAIRMAN, highlighted the critical linkages between Sustainable Development Goal 6 on water, sanitation and hygiene and Goal 3 on health. Despite being a separate goal, access to water, sanitation and hygiene must be measured in terms of its contribution to health outcomes since, without joint financing, monitoring and reporting, the integrated vision of the Sustainable Development Goals would have limited impact. Water, sanitation and hygiene must be prioritized as a component of health systems strengthening since they were at the heart of resilient community and health systems, infection prevention control and prevention of antimicrobial resistance, despite fewer than half of health facilities in developing countries having sustained access to them.

The ASSISTANT DIRECTOR-GENERAL (Health Systems and Innovation), responding to points raised, acknowledged a wide range of national and global achievements on the Millennium Development Goals and noted the lessons learned such as the importance of establishing specific targets and regular assessment of progress. There was still, however, a need to continue the unfinished business of the Millennium Development Goals in the coming fifteen years. Although the Sustainable Development Goals were very broad, delegates had pointed to a small number of common themes for the future: they included the centrality of health in the 2030 Agenda and the importance of linkages between health and the economic, social and environmental dimensions of sustainable development. She noted the request for a clear WHO strategy on how to engage with the 2030 Agenda and confirmed that the first steps had been taken in that regard.

The Committee noted the reports.

The draft resolution contained in resolution EB138.R5 was approved.¹

The CHAIRMAN noted that the Committee would resume discussion of item 13.2 following the preparation of the draft resolution on health in the 2030 Agenda for Sustainable Development.

(For continuation of the discussion and approval of the draft resolution on health in the 2030 Agenda for Sustainable Development, see the summary record of the thirteenth meeting, section 3.)

¹ Transmitted to the Health Assembly in the Committee's first report and adopted as resolution WHA69.1.

Operational plan to take forward the Global Strategy for Women's, Children's and Adolescents' Health: Item 13.3 of the agenda (document A69/16)

The CHAIRMAN drew attention to a draft resolution on committing to implementation of the Global Strategy for Women's, Children's and Adolescents' Health, proposed by the delegations of Albania, Bangladesh, Canada, Chile, Colombia, Ethiopia, India, Kenya, Liberia, Monaco, Mozambique, the Netherlands, Norway, South Africa, Sweden, Turkey, the United States of America, Uruguay, Zambia and Zimbabwe, which read:

The Sixty-ninth World Health Assembly,

PP1 Having considered the report on the operational plan to take forward the Global Strategy for Women's, Children's and Adolescents' Health;¹

PP2 Welcoming the launch by the United Nations Secretary-General of the new Global Strategy for Women's, Children's and Adolescents' Health (2016–2030) that envisions a world in which every woman, child and adolescent in every setting realizes their rights to physical and mental health and well-being, has social and economic opportunities, and is able to participate fully in shaping prosperous and sustainable societies;

PP3 Recognizing that the Global Strategy for Women's, Children's and Adolescents' Health (2016–2030) provides a road map for attaining these ambitious objectives, and that it will contribute to the implementation of the Sustainable Development Goals related to women, children and adolescents' health;

PP4 Acknowledging the importance of country actions and leadership, and of the need to prioritize the updating of national health and financing policies, strategies and plans to reflect the 17 targets included in the Global Strategy for Women's, Children's and Adolescents' Health (2016–2030), in order to advance the health and well-being of women, children and adolescents;

PP5 Recognizing the need for an equity-driven, gender-responsive life course approach, and for multistakeholder and multisector partnerships including the private sector and civil society, such as the Every Woman Every Child movement, in implementing the Global Strategy for Women's, Children's and Adolescent Health (2016–2030);

PP6 Emphasizing the crucial role of accountability at all levels, including the important role of data and information systems, and noting the work of the Independent Accountability Panel to synthesize an annual global report on the state of women, children and adolescents' health,

INVITES Member States:

- (1) to commit, in accordance with their national plans and priorities, to implementing the Global Strategy for Women's, Children's and Adolescents' Health (2016–2030), to end the preventable deaths of women, children and adolescents, to improve overall health and well-being and to promote enabling environments in a sustained and effective manner, supported by high-level commitment and adequate financing, including, as relevant, actions identified under the nine areas as proposed by the Global Strategy for Women's, Children's and Adolescents' Health (2016–2030) and its operational framework;
- (2) to strengthen accountability and follow-up at all levels, including through monitoring national progress and increasing capacity building for good-quality data collection and analysis, upon their request;

¹ Document A69/16.

(OP) 1. INVITES relevant stakeholders, as appropriate, to support the effective implementation of national plans and contribute to the accomplishment of the Global Strategy for Women's, Children's and Adolescents' Health (2016–2030) and its milestones;

(OP) 2. REQUESTS the Director General:

- (1) to provide adequate technical support to Member States in updating and implementing national plans and relevant elements of the Global Strategy for Women's, Children's and Adolescents' Health (2016–2030), including good-quality data collection and analysis;
- (2) to continue to collaborate with other United Nations agencies, funds and programmes,¹ and other relevant partners and stakeholders, to advocate and leverage assistance for aligned and effective implementation of national plans;
- (3) to report regularly on progress towards women's, children's and adolescents' health to the World Health Assembly, through the Executive Board.

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

Resolution: Committing to the implementation of the Global Strategy on Women's, Children's and Adolescents' Health	
A. Link to the general programme of work and the programme budget	
1. Please indicate to which impact and outcome in the Twelfth General Programme of Work, 2014–2019 and which output in the Programme budget 2016–2017 this draft resolution will contribute if adopted.	<p>From the Twelfth General Programme of Work, 2014–2019:</p> <p>Impact goal: Reduce under-five child mortality Outcome: Increased access to interventions for improving health of women, newborns, children and adolescents</p> <p>From the Programme budget 2016–2017:</p> <p>Outcome 3.1. Outputs 3.1.1, 3.1.2, 3.1.3, 3.1.4, 3.1.5 and 3.1.6.</p>
2. If there is no link to the results as indicated in the Twelfth General Programme of Work, 2014–2019 and the Programme budget 2016–2017, please provide a justification for giving consideration to the draft resolution.	Not applicable.
3. What is the proposed timeline for implementation of this resolution?	<p>2016–2030.</p> <p><i>If the timeline stretches to future programme budgets, please ensure that further information is provided in the costing section.</i></p>

¹ The Global Health Partnership H6: UNAIDS, the United Nations Entity for Gender Equality and the Empowerment of Women (UNWOMEN), UNFPA, UNICEF, the World Bank and WHO.

B. Budgetary implications of implementation of the resolution			
1. Current biennium: estimated budgetary requirements: US\$ 206.1 million			
Level	Staff	Activities	Total
Country offices	33.6	77.8	111.4
Regional offices	18.4	16.8	35.2
Headquarters	35.7	23.8	59.5
Total	87.7	118.4	206.1
1(a) Is the estimated budget requirement in respect of implementation of the resolution fully included within the current programme budget? (Yes/No)			
Yes.			
1(b) Financing implications for the budget in the current biennium:			
– How much is financed in the current biennium?			
US\$ 141.5 million			
– What are the gaps?			
US\$ 64.6 million			
– What action is proposed to close these gaps?			
The gap will be addressed through the coordinated resource mobilization efforts including the financing dialogue for possible financing by voluntary contribution.			
2. Next biennium: estimated budgetary requirements, in US\$ millions			
Level	Staff	Activities	Total
Country offices	–	–	–
Regional offices	–	–	–
Headquarters	–	–	–
Total	–	–	–
2(a) Financing implications for the budget in the next biennium: Information not yet available.			
– How much is currently financed in the next biennium?			
To be determined during the development of the programme budget for 2018–2019.			
– What are the financing gaps?			
US\$ millions – to be determined.			
– What action is proposed to close these gaps?			
Not applicable.			

The representative of URUGUAY, introducing the draft resolution on behalf of its cosponsors, said that it invited Member States to make a commitment to the Global Strategy for Women's, Children's and Adolescents' Health in accordance with national priorities. Recognizing the leadership role of WHO and the technical support it provided to Member States, she recommended that the Health Assembly should track implementation of the Global Strategy and provide a regular opportunity for debate on the health of women, children and adolescents. She urged the Committee to support the draft resolution.

The representative of RWANDA, speaking on behalf of the Member States of the African Region, said that reaching all 17 health-related targets of the Sustainable Development Goals was

directly linked to the improvement of women's, children's and adolescents' health, and would require paying special attention to countries with high burdens of maternal and child mortality and harnessing the power of partnership through commitment and collaboration at all levels and with all stakeholders. The Member States of his Region were fully committed to the implementation of the Global Strategy.

The representative of KENYA said that her Government was committed to the implementation of the Global Strategy and had made significant progress in developing robust national plans and priorities that would lead to the realization of Sustainable Development Goal 3. Her Government had embraced innovative partnerships that would increase sustainable financing and recognized the urgent need to eliminate inequities and promote the right to reproductive health care. Strong partnerships between governments, development partners and the private sector were crucial to providing quality, accessible and affordable health care.

The representative of BAHRAIN, noting that the health of women, children and adolescents was a high priority for his Government, said that Bahrain had succeeded in reducing the maternal mortality ratio and had adopted a number of strategies to reduce infant mortality. His Government stood ready to provide technical assistance to other countries in the region and to share best practices.

The representative of LEBANON said that her Government had incorporated the 17 targets of the Global Strategy for Women's, Children's and Adolescents' Health into its own national plan with a focus on eliminating inequities in maternal and child mortality. She welcomed the Global Strategy's emphasis on community engagement, emergency response and harmonization of global reporting through the Independent Accountability Panel. Collective action and stakeholder involvement were also vital to effective implementation. Since half of maternal, newborn and child deaths occurred in humanitarian or fragile settings, more help should be given to countries in crisis and to those hosting refugees. Technical and financial support from the H6 partnership could help countries to strengthen their data management systems.

The representative of the PHILIPPINES said that the more effective and efficient collaboration of committed stakeholders in development processes was vital to taking forward the Global Strategy and the operational framework would provide the necessary guidance to countries in achieving its aims. She supported the proposed timetable for the development of national plans, which should include investments in health that were sufficient to ensure robust implementation of the Global Strategy. National plans should also eliminate inequities in health services.

The representative of the UNITED REPUBLIC OF TANZANIA said that his Government had developed a national road map and strategic plan in line with the Global Strategy. Although the under-five mortality rate had been reduced to fewer than 54 per 1000 live births by the end of 2015, similar progress had not been made in reducing newborn mortality rates. There had been a slight decline in maternal mortality in the 10 years to 2015 and child immunization coverage was among the highest in Africa. Measures had been taken to strengthen civil registration and health information systems.

The representative of BANGLADESH, noting that children who were registered at birth stood a better chance of enjoying civil rights equitably, said that his Government had introduced universal registration of births, an electronic list of voters and a commission on information and accountability for women's, children's and adolescents' health. An individual tracking system to monitor every mother and every child had been recognized as an effective model which his Government stood ready to share with lower middle income countries in collaboration with WHO. He endorsed the draft resolution.

The representative of the UNITED STATES OF AMERICA said that Member States should prioritize the actions recommended in the report for putting the Global Strategy into practice. He

commended the commitment of the H6 partnership to strengthen coordination between partners when supporting country implementation of the Global Strategy. Success required greater coordination from all stakeholders and commitment from bilateral and multilateral development agencies. Consideration should be given to linking the goals of the Global Strategy with the draft global strategy and plan of action on ageing and health in order to strengthen a life course approach to health. He endorsed the draft resolution.

The representative of JAPAN welcomed the proposed milestones for the implementation of the Global Strategy, which Member States could use to monitor and evaluate progress. His Government was committed to strengthening service delivery, to improving the health status of women and to promoting their active role in society. Noting that the sustainable implementation of the Global Strategy would require strong political commitment and stable financial resources, he said that Member States should increase investment through domestic resource mobilization in the context of universal health coverage. He welcomed the Global Financing Facility in support of Every Woman, Every Child and expressed the hope that it would enhance the effectiveness and efficiency of programmes to improve women's, children's and adolescents' health. Japan would contribute US\$ 190 million to the Facility. He endorsed the draft resolution.

The representative of NORWAY welcomed the Global Strategy and noted that its successful implementation would require multisectoral investment and participation. The Global Strategy was relevant to women, children and adolescents everywhere, including in humanitarian settings and conflict situations. The inclusion of adolescents was commendable, since young people must be directly involved in defining needs and solutions, while access to reproductive and sexual health services were vital to girls' health, education and job opportunities. Ensuring an end to unsafe abortion practices would require an adjustment of national policies and laws to bring them into line with the relevant regional and international agreements such as the Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa (the Maputo Protocol). Country ownership and increased domestic financing were necessary to make health financing more sustainable. She encouraged additional donors to participate in the Global Financing Facility, which would help to close the financing gap in high-burden countries. Her delegation wished to be included in the list of sponsors of the draft resolution.

The representative of AUSTRALIA supported the Global Strategy and its emphasis on coordinated, multisectoral action, and encouraged Member States to work with global, regional and national partners to implement the five key recommended activities. She was pleased that the monitoring processes would be harmonized with initiatives such as the Sustainable Development Goals monitoring framework, which would reduce the reporting burden on Member States.

The representative of IRAQ said that his country had undertaken measures to promote women's, children's and adolescents' health. For example, a strategic workplan on reproductive health and maternal and child health had been incorporated into a national development strategy and had been designated as a priority by the Ministry of Health. The private sector was being urged to focus on women's and children's health, while adolescent health was being promoted through school health services. A specific workplan on neonatal health care had been developed, with an emphasis on neonatal screening and on surveillance and response, in order to reduce the rate of newborn mortality. The possibility of integrating maternal mortality and child mortality surveillance and response systems was currently under consideration.

The representative of INDIA said that the Global Strategy was a welcome initiative that would address the unfinished agenda of the Millennium Development Goals; its implementation would require leadership and ownership from every country. He noted with satisfaction that the Global Strategy recognized the need to focus on specific populations, the importance of improving the quality

of healthcare, and the need for multisectoral action. His Government was committed to ending preventable deaths and had achieved an accelerated pace of decline in mortality which exceeded the average global rate of decline. It had also instituted an ambitious immunization plan, which would see 90% of children receiving full immunization coverage by 2020. He supported the draft resolution.

The representative of the REPUBLIC OF KOREA welcomed the Global Strategy as an important contribution to the achievement of the Sustainable Development Goals and to addressing the needs of the many women, children and adolescents who still lived in unsafe circumstances. She agreed that development projects and efforts to ensure health and well-being in line with the Global Strategy would require a multifaceted approach. Her Government was due to launch an initiative to promote the health and education of girls in 15 developing countries and to enhance their future opportunities and capabilities.

The representative of GERMANY welcomed the operational plan to take forward the Global Strategy and endorsed the nine action areas set out in the Strategy, in particular with respect to humanitarian and fragile settings, health system resilience and accountability. Her Government had high hopes for the Global Strategy; it was lamentable that so many still died from easily treatable or preventable diseases. She wished to be added to the list of sponsors of the draft resolution.

The representative of CHILE said that maternal and child health policies in Chile were implemented through integrated health, family and community-based primary care and the Government supported strategies and activities to promote the health and well-being of individuals, families and the most vulnerable. She welcomed the Global Strategy, which focused on areas that had previously been insufficiently addressed. Her country had already achieved the mortality rate targets set in the Global Strategy, although regional gaps needed to be addressed and accountability mechanisms enhanced. Chile's national health strategy focused on reducing the rates of infant mortality, child development disorders, and teen pregnancy and suicide as well as on strategic goals relating to communicable and noncommunicable diseases. She called on all Member States to endorse the operational plan for implementing the Global Strategy and to support cooperation at both the regional and global levels to achieve that end.

The representative of COLOMBIA said that multisectoral action, country leadership and community participation were the means to improving the health and well-being of all women, children and adolescents. The Global Strategy and the Every Woman, Every Child initiative would contribute greatly to fighting inequality, ensuring fairer, more inclusive, sustainable and peaceful societies, and advancing gender equality and the empowerment of women and girls. Her Government had made a commitment to reduce the prevalence of chronic malnutrition in children, to increase the use of modern methods of contraception and to improve women's sexual and reproductive health. Noting the particular challenges associated with the implementation of the Global Strategy in humanitarian and fragile settings, situations of armed conflict and marginalized areas, she highlighted the need to adopt policies that were equity-driven, gender-responsive and human rights-based. Technical assistance was vital to effective implementation of the Global Strategy and the development of appropriate national plans.

The representative of TOGO welcomed the operational plan for taking forward the Global Strategy and, in particular, the objectives of ending preventable deaths, ensuring health and well-being and expanding enabling environments. There were new challenges to be faced, however, in taking into account inequities among and within countries and on the need to address environmental and social determinants of health. The mechanisms for implementation of the operational plan in different countries would depend on national needs and priorities. Each Member State must develop plans that were sustainable and had robust financing strategies. The effective monitoring and evaluation of plans

would ensure that progress under the Global Strategy could be measured at the national, regional and global levels.

The representative of PARAGUAY said that women's, children's and adolescents' health was a priority issue for her Government, which had adopted strategies and plans on the prevention of preventable deaths, the reduction of maternal and child mortality, and the promotion of adolescent health and sexual and reproductive health. Her Government was counting on technical assistance from WHO to support the implementation of those strategies and plans, and to assist in the promotion of a human rights-based and multisectoral approach. Strong investment in the health workforce would also be essential.

The representative of COSTA RICA said that Member States should continue to strengthen their national strategies in respect of women's, children's and adolescents' health, using the relevant aspects of the Global Strategy to inform actions at the national level, while keeping in mind the importance of a human rights-based approach and the principle of universal health coverage. A multisectoral approach was also crucial for the successful implementation of such strategies.

The representative of the PLURINATIONAL STATE OF BOLIVIA said that her Government had taken measures to develop national policies and plans and had stepped up activities at the community level. New legislation had been adopted to guarantee health care for pregnant women, breastfeeding mothers and children aged less than 5 years. Maternal and child health had a prominent position on the national development agenda. Her delegation supported the draft resolution, in particular operative paragraph 2 on the provision of adequate technical assistance to Member States, collaboration with other United Nations agencies and regular reporting on progress.

The representative of SOUTH AFRICA said that implementation of the Global Strategy was central to the attainment of the 2030 Agenda for Sustainable Development and the Sustainable Development Goals. Given the importance of ensuring a sustainable, evidence-based health financing strategy, the Director-General should refine the methodology available for Member States in order to produce a robust investment case for women's, children's and adolescents' health and to ensure that sufficient funds were allocated to that area of public health. Implementation plans should be Member State-led with support from partners where requested, and should follow the "Three Ones" key principles, the Paris Declaration and the Accra Agenda for Action. The Secretariat should finalize the indicator framework for the Sustainable Development Goals as soon as possible, in consultation with Member States.

The representative of INDONESIA said that her Government still had an unfinished agenda with regard to Millennium Development Goals 1, 4 and 5, which had been included, along with objectives for the implementation of the Global Strategy for Women's, Children's and Adolescents' Health, in a national development plan. The plan aimed to reduce maternal and child mortality, improve family planning, strengthen nutrition and enhance communicable and noncommunicable disease control. The drafting of an integrated strategic plan on reducing maternal and infant mortality was also under way. Provision of access to quality services for communities, in particular those living in poverty, was the key to implementing the national development plan and to reaching the targets of the Sustainable Development Goals by 2030. Efforts were being made to achieve universal health coverage and to strengthen primary health care.

The representative of the MALDIVES said that improved access to essential health interventions and services, in particular with regard to family planning, antenatal care, delivery in health care facilities and skilled birth attendance, had been the key to reducing maternal and child mortality rates in the Maldives. The increase in the burden of noncommunicable diseases remained a challenge, however, which could only be addressed by building resilient health systems. Holistic

health policies and education programmes on prevention of injury, self-harm and violence, the prevention of noncommunicable diseases, and the promotion of reproductive health were essential to ensure the health and well-being of adolescents and the protection of their human rights. To support implementation of the Global Strategy, the operational framework should include actionable milestones and realistic timelines. It should also contain clear performance indicators to monitor progress and specific actions to ensure accountability at all levels.

The representative of the FEDERATED STATES OF MICRONESIA welcomed the operational plan and draft resolution, which provided valuable guidance for Member States. Implementation of the Global Strategy would not be easy for many countries and technical support and donor assistance would therefore be essential as Member States continued to develop their national activities in line with the Sustainable Development Goals. Support from WHO and its partners would be crucial.

The representative of CANADA expressed her Government's commitment to women's, children's and adolescents' health and rights and said that implementation of the Global Strategy would be essential for attaining all the health-related Sustainable Development Goals. She highlighted the role of the Global Financing Facility in support of Every Woman, Every Child as a key mechanism for the implementation of the Global Strategy and a catalyst for leveraging domestic resources.

The representative of FRANCE said that, despite the progress made since the adoption of the Millennium Development Goals, considerable challenges to maternal and child health persisted. Each year, around the world, 6.3 million children under the age of five, 1.3 million adolescents and nearly 300 000 pregnant women died of preventable or treatable causes. The adoption of the Global Strategy in 2015 had therefore been particularly timely, and its implementation was crucial. She was pleased to announce that France would be contributing a further €10 million to the Muskoka Fund in 2016. That renewed financial commitment would contribute both to reducing maternal, child and adolescent mortality, and to reaching the ultimate goal of universal health coverage.

The representative of ARGENTINA expressed her Government's commitment to the Every Woman, Every Child initiative and to the implementation of the Global Strategy. Challenges remained with regard to aspects of the Millennium Development Goals that had not been met, and must be carried forward with the implementation of the 2030 Agenda for Sustainable Development. Her Government had adopted strategies and policies with regard to sustainable development and the promotion of health, which included all 17 targets under the Global Strategy. Efforts were being made to foster a multisectoral approach in order to ensure coherence in policies for the provision of health care and the continued strengthening of the health system.

The representative of the UNITED KINGDOM OF GREAT BRITAIN AND NORTHERN IRELAND welcomed the operational framework for the Global Strategy, which addressed some important and controversial issues such as sexual and reproductive health and rights. Her Government was committed to improving reproductive, maternal, newborn, child and adolescent health, in particular through broadened family planning coverage, as a means of bringing an end to preventable maternal and infant mortality. Her Government was providing significant funding to maternal and child health initiatives, both in the form of foreign direct investment into international funds and at the national level, to enhance training and provide equipment to prevent stillbirths and neonatal and maternal deaths. A new life chances strategy was being developed, which included measures to fight disadvantage. A ban on smoking in private vehicles had been introduced to protect children against passive smoking. Considerable efforts were being made to improve mental health services for children and adolescents.

The representative of MEXICO said that implementation of the Global Strategy was essential for all countries, in order to attain the Sustainable Development Goals. His Government recognized

the importance of cross-cutting issues, such as health systems strengthening, universal health coverage and the establishment of a sustainable and efficient health workforce, to underpin the implementation of the Global Strategy. The operational plan underscored challenges with regard to certain population groups: innovative actions were required to ensure that all adolescents received sexual and reproductive health coverage. Pregnancy was a particular risk to the life and health of adolescents in Mexico, and a national strategy had been adopted to tackle that issue.

The representative of the UNITED ARAB EMIRATES said that her Government had made considerable progress with regard to improving maternal and child health and had succeeded in reducing maternal and child mortality. The national health system had been strengthened, with emphasis on primary health care, preventive care, complementary care and rehabilitation, and care throughout the life course. A national action plan to increase breastfeeding had been elaborated and children's hospitals had been established in cooperation with UNICEF. Legislation had been adopted to regulate the marketing of food products for children. Mandatory medical examinations had been introduced for couples before marriage, and efforts were being made to ensure testing for genetic conditions and foetal examinations. Vaccination campaigns against rotavirus and poliomyelitis were also under way.

The representative of THAILAND said that the unified framework for global accountability for the Global Strategy would require good quality data and Member States should therefore enhance their data collection capacity to support decision-making. Her delegation welcomed the proposed milestones, which set actions, targets and timelines for implementation of the Global Strategy. She proposed two amendments to the draft resolution: to insert the phrase "and the milestones 2016–2017 and 2018–2020 in Annex 2 of document A69/16" between "the Global Strategy for Women's, Children's and Adolescents' Health (2016–2030)" and "to end the preventable deaths of women ..." in operative paragraph 1; and to delete the words "upon their request" from the end of operative paragraph 2.

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

The meeting rose at 17:35.

FOURTH MEETING

Wednesday, 25 May 2016, at 09:30

Chairman: Mr M. BOWLES (Australia)

1. FIRST REPORT OF COMMITTEE A (document A69/66)

The RAPPORTEUR read out the draft first report of Committee A.

The report was adopted.¹

2. PREPAREDNESS, SURVEILLANCE AND RESPONSE: Item 14 of the agenda

Implementation of the International Health Regulations (2005): Item 14.1 of the agenda

- **Report of the Review Committee on the Role of the International Health Regulations (2005) in the Ebola Outbreak and Response** (documents A69/21, A69/21 Add.1 and A69/21 Add.2)

The CHAIR OF THE REVIEW COMMITTEE listed the Review Committee's recommendations, contained in the Annex to document A69/21. Three main messages had emerged from the Review Committee's work: the need for continuous improvement in public health preparedness in the face of major risks; the need for a strong WHO Secretariat, the establishment of a standing advisory committee to review WHO risk assessment and risk communication, and the creation of a new category of alert, namely the international public health alert; and the need for solidarity among neighbouring countries and among rich and poor, in line with article 44 of the Regulations.

The CHAIRMAN invited the Committee to consider the draft decision proposed by the Secretariat in document A69/21 Add.1, which read:

The Sixty-ninth World Health Assembly, having considered the report of the Review Committee on the Role of the International Health Regulations (2005) in the Ebola Outbreak and Response,² decided:

- (1) to commend the successful conclusion of the work of the Review Committee on the Role of the International Health Regulations (2005) in the Ebola Outbreak and Response, the leadership of its Chair, the dedication of its distinguished members, and the submission of its report to the Director-General for transmittal to the Sixty-ninth World Health Assembly;

¹ See page 380.

² Document A69/21.

(2) to urge Member States to take forward the recommendations contained in the report of the Review Committee on the Role of the International Health Regulations (2005) in the Ebola Outbreak and Response;

(3) to request the Director-General to report to the Health Assembly, in the annual report on the implementation of the International Health Regulations (2005), on progress made in taking forward the recommendations of the Review Committee on the Role of the International Health Regulations (2005) in the Ebola Outbreak and Response.

The financial and administrative implications for the Secretariat of the adoption of the draft decision were set out in document A69/21 Add.2.

The representative of the DOMINICAN REPUBLIC described his country's efforts to strengthen its core capacities under the Regulations, and listed the remaining priorities, including strengthening of preparedness, surveillance and response to chemical or radiological disasters and animal and foodborne diseases. A national, multirisk emergency plan, clearly defining institutions' roles and resource management, was crucial to prepare and respond to possible threats.

The representative of the DEMOCRATIC REPUBLIC OF THE CONGO said that a joint external evaluation would be carried out as soon as possible in order to fill any gaps in his country's national action plan.

The representative of SINGAPORE said that his country, which had been affected by the outbreaks of severe acute respiratory syndrome, pandemic influenza and Zika virus infection, relied on prompt warnings of the threat of infectious disease outbreaks issued by national focal points. Core capacities should be strengthened in the broader context of improving health systems. Greater global awareness of the Regulations and a holistic communication strategy were also necessary. The Secretariat should assist countries in need and support capacity building for an effective and rapid response to emergencies.

The representative of QATAR, speaking on behalf of the Member States of the Eastern Mediterranean Region, said that, according to a rapid review conducted by WHO, progress in implementing the Regulations in the Region was patchy, even among countries which had declared themselves ready to cope with a health emergency. The Member States had called for an independent assessment and the establishment of a regional assessment commission to provide technical guidance and oversee the independent joint expert evaluations. Increased funding, regional and national partnerships and South-South cooperation were also crucial for successful implementation.

The representative of PANAMA described her country's efforts to implement the Regulations. She called upon all States Parties to fulfil their international commitments: a united and coordinated regional response, strengthened and coordinated by WHO, was the best defence against emerging and re-emerging diseases. Further discussions were crucial for a more effective approach to emergencies. She called upon States Parties to continue their assessment and training activities and warned that national and regional structures should not be weakened by excessive centralization.

The representative of the PHILIPPINES said that more resources would be needed to increase awareness of the Regulations, strengthen health systems, improve core capacities and foster active partnerships in communities in order to manage outbreaks and health emergencies. Standard metrics for measuring capacities should be strengthened at country level. Improved compliance, ownership of responsibilities and accountability were essential.

The representative of the NETHERLANDS, speaking on behalf of the European Union and its Member States, said that the candidate countries Turkey, the former Yugoslav Republic of Macedonia, Serbia and Albania, the country of the Stabilisation and Association Process and potential candidate Bosnia and Herzegovina, as well as Ukraine, the Republic of Moldova, Georgia and Andorra, aligned themselves with his statement. The preparedness required to prevent, detect and respond to health threats called for cross-sectoral collaboration. WHO should encourage transparent global governance and continue to cooperate closely with the relevant organizations, including FAO and OIE, to ensure effective implementation of the Regulations. The Regulations should be fully integrated into the new WHO Health Emergencies Programme to guarantee its emergency response capacity. The IHR Monitoring and Evaluation Framework and Joint External Evaluation Tool were crucial for identifying gaps in country core capacities and capabilities, as well as an important source of information for donors and a potential tool to coordinate support from different partners. The Secretariat should enhance existing structures and strengthen its capacity and collaboration across the different levels of the Organization. He encouraged States Parties and the Secretariat to implement the Review Committee's recommendations.

The representative of BELGIUM said that full implementation of the Regulations was a central outcome of WHO's Emergency Response Framework and noted with satisfaction that monitoring and reporting to the governing bodies were a core responsibility of the Secretariat, as the Director-General had acknowledged. The Secretariat was fully responsible for neutral, independent and objective external evaluations of core capacities, for which it should establish a clear action plan to address realistic deadlines. Donor States should provide support for countries that needed to address core capacity gaps. He proposed some amendments to the draft decision. In paragraph (2), the words "under the leadership and with the support of WHO" should be inserted between "to urge Member States to take forward" and "the recommendations contained in the report ...". In paragraph (3), the words "to take full accountability on the external independent, objective and transparent evaluation of IHR implementation process as recommended by the Review Committee, and to prepare a costed plan of action for the evaluation process in order to ensure a first round by 2021 and" should be inserted between "to request the Director-General" and "to report to the Health Assembly ...".

The representative of JAPAN said that States Parties that had yet to attain the core capacities should indicate their timetable for doing so in the IHR Monitoring and Evaluation Framework and their own national action plan, adopting a sustainable bottom-up approach. WHO, the Global Health Security Agenda partnership, the G7 Summit framework and other stakeholders were crucial to moving forward with the implementation of the Regulations, as were the collaboration and harmonization of all levels of the Organization under the "one WHO" approach.

The representative of MONACO said that her country should be fully compliant with the Regulations by 2017. She supported the amendments suggested by the representative of Belgium.

The representative of the UNITED KINGDOM OF GREAT BRITAIN AND NORTHERN IRELAND urged States Parties to expedite implementation of the Regulations in a way which supported the most vulnerable countries. It should be an integral element of health systems strengthening. She supported WHO's leading role and the external evaluation methods, and welcomed the creation of the Joint External Evaluation Tool. Her country provided financial support for implementation by low- and middle-income countries, although those countries should also allocate their own resources to carry out their national plans and build capacities.

The representative of AZERBAIJAN said that his country, with international partners, was piloting an innovative electronic disease surveillance system to facilitate timely case-by-case data collection and analysis. A major feature of the new system was the simplified method of exchanging epidemiological surveillance data with partners and the Regional Office for Europe.

The representative of the BOLIVARIAN REPUBLIC OF VENEZUELA said that cross-sectoral cooperation throughout 2015 had made it possible to maintain, consolidate and create core capacities at the country's main ports, and progress was being made in the areas of surveillance, preparedness and response, laboratory capacities and food- and animal-borne diseases. His Government had explained its position concerning the concept note "Development, monitoring and evaluation of functional core capacity for implementing the International Health Regulations (2005)" at the PAHO Regional Consultation on the IHR Monitoring Scheme post-2016, held in August 2015.

The representative of GERMANY drew the Committee's attention to the commitments made by G7 leaders during the 2015 German Presidency to support 76 States Parties in their implementation of the Regulations. Germany supported the recommendations made by the Review Committee and endorsed the findings and conclusions reflected in paragraph 157 of the report. The establishment of a global strategy, as proposed by the Review Committee, would enhance effectiveness and efficiency and help bring together existing structures and complementary initiatives. WHO must provide solid and resilient leadership in the implementation and monitoring of the Regulations. He supported the amendment proposed by the representative of Belgium to paragraph (2) of the draft decision.

The representative of the REPUBLIC OF KOREA said that the threat of emerging infectious diseases was not limited to vulnerable countries; the proposed joint external evaluation of country capacity should therefore be conducted in all States Parties. The Secretariat must give priority to the most vulnerable countries when providing support for the implementation of the Regulations.

The representative of SOUTH AFRICA commended the reform measures undertaken by WHO to fill gaps in emergency and epidemic responses. She welcomed the idea of exploring new options and mechanisms for self-assessment and voluntary peer review and external evaluation of implementation of the Regulations. States Parties required sustained support in the implementation of core capacities and ongoing reform of WHO's Emergency Response Framework.

The representative of NORWAY noted that those recommendations of the Review Committee that concerned new institutional arrangements or global strategic initiatives could not be followed up by individual States Parties: WHO must take an active lead in implementing them. The draft decision did not reflect that responsibility and should be revised. Recommendations 2, 3 and 6 of the Review Committee, at least, needed to be discussed further; any relevant decision should be deferred to the Executive Board at its 140th session.

The representative of SAUDI ARABIA said that there was an urgent need to reform WHO's existing emergency response mechanism, which was not flexible enough and did not allow for the mobilization of adequate resources. Furthermore, the mechanism did not respond adequately to emergencies caused by noncommunicable diseases and should be expanded accordingly.

The representative of SAMOA supported WHO's new Health Emergencies Programme and the "one WHO" approach. The reform of WHO's emergency work should provide ongoing momentum for further investment in preparedness work at the national level. The experience from other public health events had helped to improve response capacities, including capacity-building under the Regulations, the development of generic capacities and a step-by-step approach. He encouraged States Parties to implement the recommendations of the Review Committee.

The representative of the BAHAMAS informed the Committee about some legal and policy instruments adopted in his country. In order to address human-resource-related problems, cross-training initiatives had been increased, as had capacity to respond to radiation events. The Event Information Site had been a useful tool for sharing knowledge, best practice and achievements in the Region. In respect of the revised reporting tool, he called for regional solutions and longer reporting

intervals and guidance on follow-up action on the implementation of the Regulations beyond 2016. Periodic evaluations should be action-oriented, qualifying and quantifying progress and difficulties in each country.

The representative of FINLAND said that building country capacities to prevent, detect and respond to public health events required a sense of ownership by countries, sustained efforts and reliable information about existing gaps. She welcomed the introduction of the Joint External Evaluation Tool. Finland had been one of the first countries to undergo such an evaluation and would provide financial and other support for its rapid roll-out.

The representative of FRANCE supported the Review Committee's recommendation to develop a global strategic plan to establish and monitor core capacities and to create an intermediate level of alert. The Health Emergencies Programme should place special emphasis on building capacities at the national and regional levels. Referring to the outcome of the High-level Conference on Global Health Security (Lyon, France, 22 and 23 March 2016), he said that in order to ensure global health security all countries must have tools to prevent, detect, evaluate and communicate public health risk, and respond to it with the Secretariat's support. The new Joint External Evaluation Tool was an important development: follow-up of the evaluations should be led by the Health Emergencies Programme and regional offices. He supported the amendments proposed by the representative of Belgium in paragraph (2) of the draft decision.

The representative of TURKEY supported the draft decision.

The representative of JORDAN said that it was important to bring national legislation into line with the Regulations; strengthen surveillance systems; and equip health laboratories with diagnostic tools to detect communicable diseases. Rapid response teams were also needed. The Secretariat should keep up its support for the implementation of the Regulations in all Member States. He proposed the establishment of a centre for communicable disease surveillance and control in the Eastern Mediterranean Region.

The representative of INDONESIA, speaking on behalf of the Member States of the South-East Asia Region, said that successful implementation of the Regulations by some countries could set an example for the entire Region and thus contribute to heightened global public health security. Member States must build, strengthen and maintain core capacities and mobilize the necessary resources. She took note of the proposal for external assessment and welcomed the Global Health Security Agenda as a means for strengthening countries' core capacities.

The representative of BRAZIL, commenting that the Regulations had promoted solidarity and transparency in public health emergency responses, said that the response to the outbreak of Zika virus infection and the excellent support afforded by WHO, including PAHO, to the countries affected had illustrated the lessons learned from the Ebola virus disease outbreak.

He expressed reservations with regard to some of the recommendations made by the Review Committee. The proposed system of external evaluations would further increase the burden of compliance and must be strictly voluntary. Developing countries, in particular, might struggle to implement the proposed recommendations without new and additional international assistance. He was not in a position to consider the recommendations as an integral part, or reinterpretation, of the Regulations until they had been thoroughly examined and agreed in an intergovernmental setting within WHO. More time was needed to identify which recommendations could be implemented immediately and which ones might require amendments to the Regulations. Paragraph (3) of the draft decision should be amended to read: "to request the Director-General, in full consultation with Member States, to develop an implementation plan for the Review Committee recommendations, identifying those that would eventually require amendments of the International Health Regulations

(2005), and to submit the implementation plan for the consideration of the Seventieth World Health Assembly, through the Executive Board”.

The representative of INDIA welcomed the Review Committee’s focus on implementation and support for developing countries, but expressed reservations about recommendation 5. All countries must work towards compliance with the Regulations, but the proposed external evaluation should not be made mandatory. He also expressed reservations concerning recommendation 6: further clarification was needed on the way in which the proposed international public health alert mechanism would be implemented. The ambit and scope of recommendation 11 on data sharing also needed to be clarified. Any new mechanism developed by WHO for sharing biological samples must take full account of the Nagoya Protocol on Access to Genetic Resources and the Fair and Equitable Sharing of Benefits Arising from their Utilization to the Convention on Biological Diversity. He could not endorse the recommendations in their entirety; States Parties must be consulted about any further steps.

The representative of the RUSSIAN FEDERATION said that the implementation of the Regulations must be inclusive and transparent and uphold the independent and neutral coordinating role of WHO. Bilateral, multistate initiatives or the Global Health Security Agenda should not be placed on the same footing as the Regulations, or used as an excuse to replace them with other mechanisms. The Secretariat’s role as an intermediary between donors and States should not replace its core functions, as that would undermine trust in the Organization. He supported WHO-led monitoring of core capacities, but the proposed joint external evaluation needed to be discussed further to clarify its status and consequences. Evaluation should not be a prerequisite for support. The Secretariat must play a central, leading role in evaluation; he objected to the idea of setting up an analysis unit within the Secretariat to fulfil those functions. Until further work had been done, he could approve neither the recommendations nor the draft decision.

The representative of MEXICO said that an intermediate level of alert would allow new public health events to be dealt with promptly, but it should be carefully defined in order to avoid confusion. An appropriate communication mechanism was required, and transparency should be increased through the implementation of additional measures by States Parties and the publication of temporary recommendations.

The representative of THAILAND welcomed the Joint External Evaluation Tool, which would ensure transparency and international accountability in respect of the core capacities, although it was unclear how much it would cost and who would pay for it. The Secretariat should focus on core capacities for assessment and on priority countries. Given the imposition by some countries of international travel restrictions that went beyond the temporary recommendations, he encouraged the Secretariat to play a leading role in ensuring adherence to temporary recommendations.

The representative of EGYPT called for greater financial support, human resources and capacity building for regional offices. Owing to the scale of the response required, caution should be exercised when declaring a public health emergency of international concern. The causal link between Zika virus infection and microcephaly had not been confirmed: WHO should not overreact before that link had been established.

The representative of NEW ZEALAND said that the Review Committee’s recommendations should be implemented urgently. The Secretariat should prioritize funding and cooperation to support States Parties in the sustainable development of the health systems infrastructure required to implement the Regulations fully. Progress towards universal health coverage would deliver local, regional and global health benefits and improve health security and responsiveness to future health emergencies.

The representative of AUSTRALIA welcomed the report by the Review Committee and supported its recommendations. He expressed support for the Joint External Evaluation Tool and the Secretariat's approach to evaluating implementation. He supported the draft decision and reserved the right to respond in due course to the amendments proposed.

The representative of CÔTE D'IVOIRE said that financial and technical support provided through the United Nations system and the Global Health Security Agenda had helped to strengthen prevention, detection and response capacities for public health emergencies.

The representative of PAKISTAN said that his country had been the first in the Eastern Mediterranean Region to undergo the joint external evaluation exercise, which had helped it to identify capabilities, gaps and challenges in implementation. He urged other States Parties to follow suit.

The representative of ETHIOPIA, speaking on behalf of the Member States of the African Region, said that the lack of vaccines and treatments for Ebola virus disease should be added to the issues identified by the Review Committee. African countries continued to make progress in implementation and agreed that implementation and the development and roll-out of a global strategic plan should be prioritized. Ethiopia, Mozambique, Uganda and the United Republic of Tanzania had conducted risk and core capacities assessments using the Joint External Evaluation Tool. Member States in the Region remained committed to establishing and sustaining capacity to prevent, detect and address public health emergencies. WHO and other stakeholders should implement the Review Committee's recommendations, in particular those related to developing capacity for laboratory diagnosis and using technology to boost surveillance and ensure the timely reporting of public health emergencies.

The representative of the UNITED REPUBLIC OF TANZANIA said that it was crucial to build capacity, particularly in respect of food, chemical and radio-nuclear risks, areas in which the African Region performed poorly. Linkages between the Regulations and the Pandemic Influenza Preparedness Framework should be strengthened, as both addressed core capacities for surveillance and response. The proposed global strategic plan should outline operational goals for one, five and ten years, and allow for the holding of periodic reviews. The plan required an implementation framework, which should be developed in consultation with States Parties and the WHO regional committees. Independent assessment should be performed regularly at the regional level, in order to strengthen regional linkages and the exchange of technical expertise. She expressed concern at the recommendation to establish a standing advisory committee to define an intermediate level of alert, particularly if no support was associated with it, and requested detailed information in that regard. Nevertheless, she supported the draft decision.

The representative of KUWAIT endorsed the report by the Review Committee and noted the importance of financial and technical support from WHO. The efficient delegation and empowerment of regional offices would allow the better use and faster mobilization of resources. Despite recognition of the importance of national IHR Focal Points, there were no specific indicators on strengthening their function.

The representative of BURUNDI expressed support for the draft decision. Despite its limited resources, his country had worked with partners to implement the Regulations.

The representative of BARBADOS said that the Regulations represented best practice in global disease prevention and control, which was crucial for small island States with economies based on the free movement of people and services. Member countries of the Caribbean Community required the Secretariat's support to strengthen laboratory systems and response capabilities; develop a legislative

framework for compliance; and develop mechanisms for a timely response to chemical, biological and nuclear events. He called for a regional framework for monitoring, evaluation and response with respect to such threats. Given the constraints faced by countries in the region, the evaluation of compliance should, in the short term, be conducted by Member States in the region.

The representative of CANADA emphasized the importance of timely implementation. A global strategic plan would require broad consultation, yet swift development. The Secretariat should immediately initiate the development of that plan, with a view to the Executive Board discussing it at its 140th session.

The representative of SRI LANKA described his country's experience of implementing the Regulations with reference to the outbreak of Ebola virus disease. Its WHO country office had provided assistance and a survey had found no suspected case of the disease.

The representative of KENYA said that implementation of the core capacities in his country had been hindered by resource constraints and political change. He looked forward to the development of a fully resourced global strategic plan and recommended an emphasis on sustainable funding for long-term health system strengthening. Embracing the Global Health Security Agenda would accelerate implementation. The global strategic plan should be reviewed every three years to ensure that it was addressing identified gaps in implementation, and the Secretariat should consult States Parties before finalizing it. He supported the use of the Joint External Evaluation Tool to review the core capacities.

The representative of VIET NAM said that the Joint External Evaluation Tool would help States Parties to implement the core capacities and mitigate their reporting burden. The Secretariat should draft and issue a guidance manual and training programme on the tool.

The representative of BANGLADESH noted the importance of implementation in a context of disease outbreaks that threatened health systems. Despite global progress on implementation, certain areas – such as chemical and radio-nuclear risks and implementation at points of entry – had progressed slowly. The strengthening of surveillance, health systems and response capacity in each State Party should be emphasized, rather than a focus on a single health problem or condition. His country would welcome technical assistance in the areas of multisectoral preparedness and response and strengthening of physical structures at points of entry. He proposed that, at the end of the final sentence of the draft decision, the following phrase should be added: “in addition to progress of outbreaks and response to other diseases of public health concern”. States Parties' concerns about certain recommendations by the Review Committee should be addressed, with a view to reaching a consensus.

The representative of PARAGUAY supported the creation of an intermediate level of alert, which should be accompanied by information on the availability of products and equipment required to launch a national response. The development of the global strategic plan to improve public health preparedness and response should comprise realistic time-bound targets to be achieved with the Secretariat's support. Self-assessment of core capacities should be continued and external assessment should be conducted by regional experts, with national participation. The rapid sharing of public health and scientific information and data had ensured a sound national response to the outbreak of Zika virus infection in Paraguay; related procedures should be improved.

The representative of the UNITED STATES OF AMERICA said that the Review Committee's recommendations must not be ignored. Implementation of the Regulations should be linked with broader efforts to strengthen health systems and a multisectoral approach was critical to address public health emergencies. The Joint External Evaluation Tool was an essential component of a robust IHR

Monitoring and Evaluation Framework, and her country was currently undergoing its own joint evaluation. She supported the statements by the United Republic of Tanzania and Norway.

The representative of GRENADA congratulated the Review Committee and aligned himself with the statements made by Barbados and the Bahamas.

The representative of CHINA said that accelerated implementation of the Regulations took priority over their revision and was essential to safeguard global public health. China had enhanced its emergency response core capacities in line with the Regulations. It welcomed the leadership of WHO in implementing the Regulations.

The representative of IRAQ described the intersectoral links established in his country for the implementation of the Regulations. A specialized unit had been established under the Ministry of Health and legislation had been adopted for the swift implementation of the Regulations, particularly at times of pilgrimage. He called on WHO to provide further technical assistance.

The representative of TUNISIA said that national contexts should be taken into account when giving effect to the Review Committee's recommendations. Risk assessment capacities should be improved through training, with priority support being provided for developing countries. Data security and other ethical considerations must be taken into account in the implementation of recommendation 11 on improving rapid sharing of information.

The representative of GHANA pointed out that, as the Ebola virus disease outbreak had demonstrated, the international community was ill-prepared in the face of public health threats. States Parties should prioritize funding for the Regulations as a social and economic investment.

The representative of PAPUA NEW GUINEA endorsed the statements made by Samoa and Japan. It was vital to strengthen core capacities as part of the overall strengthening of the health system itself. Her country would not have some the core capacities by the final deadline of June 2016, but it had responded in the areas most affected by the El Niño weather phenomenon and Zika virus infection by implementing the core capacities at points of entry in the country. Field epidemiology training was conducted with the support of the Secretariat, the United States of America and Thailand, with the aim of assigning field epidemiologists to each province to assist in disease control and emergency preparedness.

The representative of the ISLAMIC REPUBLIC OF IRAN said that recent outbreaks of certain prototypical diseases indicated insufficient preparedness of many countries to deal with global health emergencies. The Secretariat should organize regional consultations on the IHR Monitoring and Evaluation Framework to ensure that all States Parties were fully involved and informed irrespective of political considerations. His country had launched a successful early warning and surveillance programme and intended to share it with other countries, with WHO coordination.

The representative of ECUADOR said that the Regulations had aided the country's effective response to the earthquake of April 2016. Her country had drafted a strategic plan based on the core capacities and had prevented post-disaster outbreaks of disease with the support of WHO and PAHO. She called for further technical assistance from the Secretariat.

The observer of CHINESE TAIPEI said that the Event Information Site had allowed for prompt access to information on several major public health threats in Chinese Taipei and enabled it to work closely with partners regarding preparedness and response. He urged States Parties to comply fully with the Regulations, particularly the provision stipulating notification of a potential public health

emergency of international concern within 24 hours, and to make use of the Joint External Evaluation Tool.

The representative of the INTERNATIONAL ORGANIZATION FOR MIGRATION said that implementation of the Regulations should take into account the critical link between health, migration and human mobility within countries and across borders. It was crucial to monitor population mobility dynamics in order to identify spaces of vulnerability and subsequently strengthen core capacities for emergency preparedness and response and primary health care. Her organization would continue to advocate for mobility-sensitive public health emergency preparedness and response plans and provide the relevant technical assistance. She called upon governments and partners to ensure that migrants, regardless of their status, were included in preparedness and response plans to guarantee public safety.

The CHAIR OF THE REVIEW COMMITTEE said that the implementation of recommendation 5 on the external assessment of core capacities would constitute real progress, although it was not an obligation. All stages relating to its implementation should be guided and overseen by the Secretariat. The coordinated actions following an intermediate-level alert under recommendation 6 would be determined with the full participation of relevant stakeholders and the support of the Secretariat. With regard to recommendation 11, he noted that the Nagoya Protocol laid down guidelines on access and benefit sharing to address the sensitive questions inherent in the rapid sharing of public health and scientific information. WHO's research and development blueprint for action to prevent epidemics could inform the implementation of that recommendation. In addition, the Pandemic Influenza Preparedness Framework could serve as an example for the development of the Regulations.

The DIRECTOR-GENERAL expressed her thanks to States Parties for reaffirming by consensus the central role of WHO in the implementation of the Regulations. It was incumbent on States Parties to make a commitment to implement the core capacities defined in the Regulations, but States Parties had recognized the limits of self-assessment and would welcome WHO's coordination of various initiatives and voluntary participation in the Joint External Evaluation Tool. While it was imperative to ensure that recommendations of the Review Committee that were consistent with the Regulations were swiftly put into effect to ensure preparedness for future emergencies, the opportunity would be provided for dialogue on the recommendations that required further clarification and discussion prior to adoption. In that connection, she proposed that the Secretariat should draft a global strategic plan to improve public health preparedness and response, including technical and financial resource mobilization to implement the plan, which would be submitted to the regional committees for discussion. Feedback would be gathered, particularly from States Parties for which implementation of the Regulations imposed additional burdens or necessitated legislative amendments. A consolidated version based on those discussions would then be submitted to the Executive Board in January 2017 and subsequently the Seventieth World Health Assembly. Accordingly, the Secretariat would revise the draft decision, incorporating as necessary the proposed amendments and setting out a timeline for action, for later consideration by the Committee.

The representatives of the UNITED KINGDOM OF GREAT BRITAIN AND NORTHERN IRELAND, SOUTH AFRICA and MALAYSIA expressed support for the Director-General's proposal.

The representative of BRAZIL said that the Director-General's proposal offered an excellent way forward, although there were core elements still to address. It was important to be flexible and give the Director-General the capacity to implement those elements that were consistent and compatible with the current Regulations. Some elements were novel, such as antimicrobial resistance and the external evaluations; their implications required further discussion.

The representative of NIGERIA expressed support for the Director-General's proposal, but said that some key actions should be taken immediately and that prolonged bureaucratic procedures should not be allowed to delay capacity-building.

The representative of SUDAN, endorsing the Director-General's proposal, said that the Regulations must henceforth be treated as a reality, not as an ambition. Sudan would work closely with the Regional Office for the Eastern Mediterranean to fulfil the requirements for implementation.

The representative of the RUSSIAN FEDERATION said that the need for swift action must be balanced against the need for further discussions. As the Regulations were a legally binding instrument, it was essential to ensure consensus, without leaving any loopholes. He therefore supported the Director-General's proposal.

The representative of MEXICO supported the proposal and expressed his commitment to work constructively with the Secretariat and other States Parties to reach consensus.

The representative of NICARAGUA, welcoming the Director-General's proposal, considered the regional consultation process to be of particular importance in order to ensure implementation of not only the Regulations, but also the mechanisms for emergency preparedness and response.

The representative of SAUDI ARABIA supported the Director-General's proposal. It was important to support the external evaluation of States Parties' core capacities and to highlight any gaps.

The representative of EGYPT warned against the possibility of bureaucratic delays and called for them to be kept to a minimum.

The representative of CHINA supported the use of external evaluations and highlighted the importance of consistency in the use of experts and resources under the IHR Monitoring and Evaluation Framework.

The representative of INDIA, supporting the Director-General's proposal, stressed that the recommendations must be reviewed and discussed.

The DIRECTOR-GENERAL expressed her appreciation for the strong support given to the proposed way forward.

The CHAIRMAN took it that the Committee wished to suspend consideration of the agenda item, to allow time for the Secretariat to prepare 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 thirteenth meeting, section 2.)

Reform of WHO's work in health emergency management: WHO Health Emergencies Programme: Item 14.9 of the agenda (documents A69/30 and A69/61)

The representative of the UNITED KINGDOM OF GREAT BRITAIN AND NORTHERN IRELAND, speaking in her capacity as Chairman of the Programme, Budget and Administration Committee of the Executive Board, said that the Committee had considered the Director-General's report on the reform of WHO's work in health emergency management (document A69/30). In

acknowledgement of the late posting of the report, members had considered that it would be premature to recommend adoption of the decision by the Health Assembly; instead the Committee had recommended, on behalf of the Executive Board, that the Health Assembly should note that report, continue the discussion started in the Programme, Budget and Administration Committee and consider the proposed draft decision contained in paragraph 24 of document A69/30, taking into account the need to ensure full and sustainable financing for the WHO Health Emergencies Programme.

The representative of MALAYSIA, speaking on behalf of the Member States of the Western Pacific Region, supported the new WHO Health Emergencies Programme, particularly the concept of “one WHO” during health emergencies. The new implementation plan might usefully draw on the Asia Pacific Strategy for Emerging Diseases. He welcomed the Joint External Evaluation Tool as an appropriate and complementary way of identifying and filling gaps in Member States’ national plans.

The representative of JAPAN said that there were three critical factors in preparing for and responding to future health emergencies: implementation of the health emergency reform; global coordination of large-scale health emergencies, with agreed standard operating procedures and with WHO taking the central role and coordinating with the United Nations Office for the Coordination of Humanitarian Affairs and other existing agencies; and securing sufficient financial resources. Japan would take up health as a priority agenda item at the G7 Summit, which it was due to host shortly. It had already contributed US\$ 11 million to the WHO Contingency Fund for Emergencies, and its Prime Minister had pledged US\$ 1100 million for global health institutions, including US\$ 50 million over the coming years for Japan’s contribution to the directly relevant health emergency activities of WHO. She encouraged other Member States to support the health emergency reform efforts.

The representative of COLOMBIA, speaking on behalf of the Region of the Americas, supported the WHO Health Emergencies Programme and welcomed the progress made. Since 1976, the PAHO Emergency Preparedness and Disaster Relief programme had proven to be an efficient and effective emergency and disaster response mechanism in the Region. The Member States of the Region therefore supported the new programme on the understanding that the PAHO programme would continue to respond fully to the health emergency needs of Member States in the Region, but would work in coordination with the WHO Health Emergencies Programme, as appropriate.

The representative of the NETHERLANDS, speaking on behalf of the European Union and its Member States, said that the candidate countries Turkey, the former Yugoslav Republic of Macedonia, Serbia and Albania, the country of the Stabilisation and Association Process and potential candidate Bosnia and Herzegovina, as well as Ukraine and the Republic of Moldova and Georgia, aligned themselves with his statement. He welcomed the development of a single Health Emergencies Programme, the establishment of the Independent Oversight and Advisory Committee and the launch of a transparent selection process for the Programme’s Executive Director. He urged the Secretariat to implement the recommendations of the Advisory Group on Reform of WHO’s Work in Outbreaks and Emergencies with Health and Humanitarian Consequences in full, by rolling out one workforce, one budget and one clear line of authority throughout the Organization. He recognized the need to expand the Secretariat’s current operational capacity, but emphasized that the Secretariat should also rethink its priorities within the existing programme budget. Health emergency preparedness must be reinforced through strong country and regional capabilities, supported by WHO regional offices, an activity that should be reflected in the budget. He requested an update on the preparation of the Proposed programme budget 2018–2019 and on the proposal to secure additional funding for the Contingency Fund for Emergencies to reach the target of US\$ 100 million and ensure efficient replenishment mechanisms were in place.

The representative of MONACO said that WHO should maintain its leadership role in health responses to emergencies, with one clear line of authority. She pointed out a possible ambiguity in paragraph 6 of document A69/30 regarding Grade 2 crises, and asked for the procedure to be clarified. The planned one-off budget increase for the biennium 2016–2017 for the new programme should be made permanent, and an explanation be provided for how the funds would be sourced. If it was deemed appropriate to submit a proposal to the Executive Board for an increase in compulsory contributions, it should be included in the draft decision.

The representative of the UNITED KINGDOM OF GREAT BRITAIN AND NORTHERN IRELAND welcomed WHO's progress in reforming its response to disease outbreaks and health emergencies, and requested further details of the new programme's structure and budget. However, the Secretariat must do more, including full and rapid implementation of the Advisory Group's recommendations. His country had made a substantial contribution to the Contingency Fund for Emergencies and encouraged other Member States to follow suit. The world was watching; WHO and the international community must show that it had learned the lessons from the Ebola virus disease outbreak. WHO must be much better prepared for future outbreaks and emergencies. He strongly endorsed the new programme and urged its swift implementation.

The representative of SWITZERLAND welcomed the concept of a single unified programme and the strengthening of the Secretariat's operational capacities to make them a central pillar of the Organization. The new programme was a step towards that goal. She likewise welcomed the development of a single, common results framework to standardize planning, budgeting, staffing, monitoring and feedback, and discussions taking place on collaboration with the United Nations Office for the Coordination of Humanitarian Affairs to establish operational methods to integrate the management of disease outbreaks. She agreed that the request for extra budget funds was justified and a necessary investment.

The meeting rose at 13:00.

FIFTH MEETING

Wednesday, 25 May 2016, at 14:35

Chairman: Mr M. BOWLES (Australia)

PREPAREDNESS, SURVEILLANCE AND RESPONSE: Item 14 of the agenda (continued)

Reform of WHO's work in health emergency management: WHO Health Emergencies Programme: Item 14.9 of the agenda (documents A69/30 and A69/61) (continued)

The representative of SENEGAL said that the countries affected or threatened by Ebola virus disease were taking action to ensure a more effective response to any future epidemics and health emergencies. The new WHO Health Emergencies Programme should support national initiatives for strengthening health systems and implementing the International Health Regulations (2005) as well as regional initiatives launched by the Economic Community of West African States and the African Union, with which areas of collaboration should be established. The Health Assembly should formulate recommendations to that effect.

The representative of ZAMBIA, speaking on behalf of the Member States of the African Region, said that there should be greater coherence between the work on health emergencies and that on related areas such as the framework of engagement with non-State actors and regional initiatives in the Region. He would welcome greater clarity on the implementation of the new Programme at regional and country levels. The Secretariat should improve the coordination of its health emergencies work with regional and subregional bodies in Africa. The countries of the Region remained concerned about the limited resources and capacity available to the Regional Office and the country offices for response to public health emergencies. The reform work should focus on building capacity at local level within reasonable time limits. Ensuring preparedness with regard to financing was the responsibility of Member States under the International Health Regulations (2005), yet Member States in the Region would welcome support from partners. Adequate resources must be allocated to preparedness in order to strengthen their health systems. It was also important to strengthen health information systems.

The representative of LEBANON, speaking on behalf of the Member States of the Eastern Mediterranean Region, said that the Region currently faced a number of health emergencies. Despite the remarkable efforts of the Regional Office, there was a risk that the situation would deteriorate, owing to lack of financing. Adequate resources should be provided to support the role of WHO and first responders at country level. It was unclear whether the current and future funding for the Programme would be directed where it was most needed. Support for countries with the greatest immediate needs should be increased and clear lines of authority and accountability established. Building regional capacity would help to ensure that the Programme was properly implemented. The capacity and leadership of regional and country offices would determine the effectiveness of WHO's response. It was important to restore trust in WHO's ability to lead and coordinate health emergency response and outbreak control, and Member States should work with the Secretariat to fill gaps in the Organization's capacity. Investment in the new Programme was necessary, but it should not come at the expense of other priority areas of the programme budget. He strongly supported the draft decision contained in document A69/30.

The representative of SAUDI ARABIA said that it was important to build on the existing structures at the three levels of WHO, with a focus on the weakest link in emergency response: the first responders in the countries concerned. Countries should be consulted to determine their specific needs, and clear roles in health emergency response should be defined at the regional and local levels. His Government's experience of dealing with outbreaks of Middle East respiratory syndrome coronavirus infections had underscored the need to work with other sectors and with local communities. It had also shown the importance of periodic evaluations and investment in scientific research. Cooperation should be enhanced between the relevant ministries and sectors of society and the international community. Funding for the new Programme should be allocated under the Organization's programme budget.

The representative of IRAQ said that his country's health care system had been seriously overtaxed by a series of crises and emergencies. Support from WHO and the international community in that regard would be welcome. The new Programme would improve not only emergency response but also emergency preparedness, and Member States and donors should make available the funds required to implement the Programme and deliver assistance to countries experiencing crises. Global solidarity was more essential than ever in order to ensure international health security.

The representative of the REPUBLIC OF KOREA said that his country's experience with the Middle East respiratory syndrome coronavirus outbreak argued for centralizing control and clarifying the roles of relevant organizations in emergencies. Selecting an Executive Director for the overall management of public health emergencies made sense, but the roles and responsibilities of the regional directors, regional emergency directors and the Director-General needed clear definition.

The representative of TURKEY, welcoming the efforts to enhance WHO's emergency response capacity in the wake of the Ebola virus disease crisis, said that the Director-General's authority to relocate staff within 72 hours should be strengthened. Global response capacity was the sum of capacities at all levels of the Organization. Lack of health system preparedness was particularly evident in areas such as the Eastern Mediterranean Region, which had experienced mass displacement of populations. His Government was making every effort to relieve the consequent negative health outcomes. It looked to WHO to carry out its mandate, live up to its reputation and meet global needs by implementing emergency reforms swiftly and effectively.

The representative of TOGO said that the new Programme would enhance the Organization's capacity to respond to humanitarian emergencies. He welcomed the initiatives introduced by the Director-General to establish the Emergencies Oversight and Advisory Committee, create an implementation plan and seek funding for the Programme.

The representative of MYANMAR, speaking on behalf of the Member States of the South-East Asia Region, said that the action taken, resources allocated and investments made under the Programme should be directed at strengthening country capacities. Financial, operational and technical support needed to be decentralized. The concentration of emergency management staff at headquarters was a matter of concern, as emergency response had to be addressed at the country level. He asked how the Programme would function if no voluntary contributions were provided; which Programme activities and components would be scaled down and at which levels of the Organization if the necessary US\$ 160 million in funding could not be mobilized; and, how, if funding was derived solely from the reallocation of existing resources, would other priority programmes be affected. The distribution of resources among preparedness, prevention and response activities should be balanced. He fully supported the adoption of the draft decision.

The representative of DENMARK, expressing support for the new Programme, said that WHO needed to cooperate effectively with non-State actors in its response to health emergencies and

actively involve communities and affected populations. Attacks and threats against humanitarian assistance personnel severely restricted the provision of support to populations in need, and parties to armed conflict should therefore take steps to prevent such violence. Ensuring the full implementation of the International Health Regulations (2005) was a shared responsibility. Many Member States required support to establish the core capacities under the Regulations, and he therefore welcomed the prioritization of country preparedness under the new Programme. Transparent external country assessments with context-specific analyses and recommendations would also be welcome.

The representative of the UNITED REPUBLIC OF TANZANIA said that the new Programme should have clear lines of accountability and responsibility. Its emergency response activities should be coordinated between all three levels of the Organization. A better understanding was needed of the link between the Emergencies Oversight and Advisory Committee and the WHO regional committees. Technical capabilities, geographical diversity and gender should be considered when appointing members of that Committee. His Government supported ongoing collaboration between WHO and the United Nations Office for the Coordination of Humanitarian Affairs in the response to large-scale disease outbreaks.

The representative of the PHILIPPINES supported the new Programme and welcomed the clear delineation of the roles and responsibilities of the Emergencies Oversight and Advisory Committee, the Executive Director, the regional directors and the WHO representatives. He underlined the important responsibility of WHO representatives and country offices in implementing Programme activities. Collaboration with the United Nations Office for the Coordination of Humanitarian Affairs in managing health emergencies was also essential. He supported the draft decision.

The representative of EGYPT said that, if the aim of the Programme was to expedite response to emergencies, authority for operational planning should be given to the regional and country offices, not the Executive Director. It was also essential to ensure that regional and country offices received adequate resources. The lines of authority between the Executive Director and the regional directors in Grade 2 emergencies should be clarified in order to avoid confusion that might hinder timely response.

The representative of NEPAL said that the experience of the 2015 earthquake in his country had highlighted the need for capacity development at all levels of the health system and in other relevant sectors, decentralization of resources to subnational and local levels, management of coordinated multisectoral involvement and implementation of a surveillance mechanism for timely identification of potential and real threats. The Programme should take a comprehensive approach, supporting Member States not only through emergency response, but also during recovery and rehabilitation following an emergency. He supported the adoption of the draft decision.

The representative of the UNITED STATES OF AMERICA said that his Government firmly supported the proposed emergency management reforms, recognized the need for an increase in the programme budget to support the new Programme and considered the request to mobilize additional voluntary contributions was reasonable. The Director-General must be given clear authority to respond appropriately to outbreaks and emergencies; that did not mean, however, that all functions and responses should be centralized in Geneva. The roles of the regional and country offices should be clearly defined and functional collaborative relationships with the United Nations Office for the Coordination of Humanitarian Affairs and the wider humanitarian assistance coordination system should be established by the end of 2016. Key technical programmes, such as the Global Influenza Programme, should be preserved and prioritized within the organizational structure of the Health Emergencies Programme. Both existing programmes and new multi-organization coordination mechanisms must be able to thrive in the new structure. It was disappointing to hear some delegations predicting the Programme's failure and asking where budgets would be cut. If the emergency management reforms were to succeed, they must be embraced by all.

The representative of NORWAY said that the work on health emergency management should be integrated into the whole of WHO's work, with heads of country offices and regional directors fully engaged in incident management decision-making and in the functioning of the new Programme. Prevention efforts should be intensified in line with the International Health Regulations (2005), and the Secretariat should support Member States more effectively in implementing the Regulations. The Secretariat should also enhance the capacity of its staff to work in coordination with humanitarian response partners. Stronger and more visible leadership of health clusters was needed, as were stronger links with other humanitarian clusters. The proposed reforms had been 18 months in the making, and it was time to move forward; she considered that the draft decision provided a viable basis for doing so and urged its adoption.

The representative of CANADA fully supported the lines of accountability under the new Programme, welcomed the Organization's increased engagement with the global humanitarian sector and applauded its commitment to strengthening the secretariat of the Global Outbreak and Alert Response Network. She welcomed also the progress made on strengthening the global health emergency workforce, for which her country remained committed to mobilizing personnel. Priority should be given to monitoring and reporting of compliance with the International Health Regulations (2005). She supported the new joint external evaluation tool. Stability and strength of leadership would be central to the success of the new Programme and she therefore keenly awaited the timely appointment of its Executive Director.

The representative of the RUSSIAN FEDERATION, expressing support for the new Programme, said that standardization of emergency response approaches, including comprehensive risk assessments, would complement WHO's traditional technical and normative roles. He asked why the cost of implementing the Programme had not been taken into account in the Programme budget 2016–2017, as the health emergency management reforms had been agreed and approved in January 2015.

The representative of the FEDERATED STATES OF MICRONESIA said that much work remained to be done to ensure adequate emergency preparedness, surveillance and response. Controlling localized outbreaks before they became public health emergencies of international concern would require resources and capabilities that many Member States currently did not have. The Asia Pacific Strategy for Emerging Diseases would help to strengthen capacity for emergency response in the Western Pacific Region. He supported the concept of a "one WHO", all-hazards approach and the allocation of more resources to regional and country offices to enable them to be more responsive to emergencies and crises.

The representative of MEXICO supported the proposed emergency management reforms but said that they should be guided by Member States and by the principles of accountability, transparency, efficiency, effectiveness and equity. They should also take due account of regional and national needs, which should be assessed. A comparative analysis should also be prepared to compare how WHO would respond to different emergency situations after the reforms were implemented with how it currently responded. He sought clarification of the placement of the new Programme into the current programmatic structure which had been approved by Member States; the indicators to be used to evaluate the Programme and how they would relate to the current impact indicators; how the emergency management structure would be replicated at the three levels of the Organization; and what accountability mechanism would be used at the three levels. The proposal to increase the programme budget without an exhaustive analysis of spending and resources was worrying. Member States should be presented with options other than a budget increase.

The representative of SPAIN said that, although Member States agreed on the need to ensure that WHO had sufficient capacity to respond to health emergencies, the proposal to significantly

increase the Organization's programme budget raised concerns. The report by the Director-General (document A69/30) did not adequately explain what efficiency and spending control measures had been adopted in order to be able to secure resources for the Programme. By reducing spending in areas such as travel and health insurance, the Secretariat could free up a significant amount of funding for the new Programme. Existing staff should be relocated whenever possible in order to avoid hiring new staff. In addition, the Secretariat should present a plan for reducing budgetary allocations to lower-priority programmes and activities. Only after those measures had been taken would his Government be prepared to discuss a possible rise in assessed contributions.

The representative of THAILAND, expressing support for the proposed reforms, said that the successful implementation of the Programme would require strong and committed leadership to steer all three levels of the Organization towards systemic change. WHO should collaborate closely with other United Nations organizations and global health partners.

The representative of BRAZIL said that the use of resources to improve WHO's capacity to respond to health emergencies should be subject to ongoing discussion, monitoring and assessment. He noted with concern the intention to make the Executive Director responsible for developing a single budget and staff plan; Member States should be consulted in that regard and the approval of the Programme, Budget and Administration Committee and the Health Assembly should be sought. It would be prudent to await the outcome of regional consultations on the recommendations of the Review Committee on the Role of the International Health Regulations (2015) in the Ebola Outbreak and Response before aligning the WHO Health Emergencies Programme with those recommendations. He sought clarification on how relocation of staff under the Programme would work in practice; for instance, it would be useful to know whether staff currently working on emergency management would move to the new structure, and how disruption or understaffing in other areas would be prevented. The allocation of resources to the new Programme should not divert resources from WHO's core functions and mandates.

The representative of ECUADOR said that her country's experience following the earthquake in April 2016 had underscored the need to ensure transparency and accountability in the management of emergency situations and the importance of participation by Member States in decision-making, especially in emergency situations. Such participation would facilitate coordination of the supply of medicines and medical equipment and help to strengthen national capacity and channel donated funds to the first phase of emergency response so that the country's own resources could be reserved for the post-emergency recovery phase.

The representative of ITALY said that the emergency response capacity of the regional and country offices must be ensured. Personnel with the required training must be recruited and their skills must be continuously developed. The ability to mobilize resources from Member States and other relevant partners, including nongovernmental organizations, was also needed. It was crucial for WHO to liaise with other global entities and use their expertise and resources. Such collaboration might allow for budget restructuring, with a greater focus on action rather than support for a new bureaucratic structure. A human rights-based approach should be applied in all health emergency situations, so that nobody was left behind. Protection against attacks should also be ensured for all health facilities and workers, including those affiliated with nongovernmental organizations.

The representative of MALDIVES said that her country, like other small island States, continuously faced challenges in grappling with the negative impacts of rising sea levels and other adverse effects of climate change, which resulted in frequent emergency responses and risk management situations. Her Government welcomed the proposed unified emergency response and management mechanism. To ensure that the new Programme worked effectively, it would be

important to ensure efficient coordination between existing WHO functions at the regional and country levels with the new structure.

The representative of GERMANY, welcoming the proposed design and functions of the new Programme, said that WHO should pursue a systematic approach that would better integrate its health crisis management work with that of the overall United Nations humanitarian system. His Government supported the recommendation of the Secretary-General's High-Level Panel on the Global Response to Health Crises that WHO should strengthen its leadership and establish unified, effective operational capacities for emergency management. It recognized, however, that additional financial resources would be needed to achieve and maintain the necessary capacity at all levels of the Organization. As Member States had agreed that WHO should remain the lead organization for global health, a frank discussion of how to ensure sustainable financing for its health emergency management activities would be needed in the near future.

The representative of INDIA said that the Programme's structure should be lean and flexible. Its staff at all levels of the Organization should be encouraged to multitask so that their services and skills were fully utilized in non-emergency times. When delegating responsibility to the Executive Director and regional directors, the Director-General should bear in mind that each emergency situation was unique. A clearer description of the role of the Executive Director was needed, and it must ensure that his or her authority did not undermine that of the Director-General or the regional directors. Greater clarity and transparency were also needed with regard to how country vulnerabilities had been classified and how priority countries had been identified. He reiterated his opposition, expressed in the discussion of item 14.1 in the previous meeting, to the idea of mandatory external evaluation of core capacities under the International Health Regulations (2005) and therefore could not support its inclusion in the WHO Health Emergencies Programme. Before seeking approval of a budget increase for the Programme, the Secretariat should conduct a proper assessment to determine how many countries would seek voluntary external assessment and whether it had the capacity to oversee those evaluations, which accounted for a significant part of the proposed increase.

The representative of SRI LANKA said that his Government recognized the importance of reforming WHO's work in health emergency management and had taken measures to align its disaster management framework with WHO's reforms. Infectious hazards management had been enhanced through its integration into the health system at all levels, the national strategic plan for disaster management was being reviewed with a view to improving emergency preparedness and response capacity, an emergency operations centre had been established and the country's health emergency information system was being upgraded.

The representative of CHINA said that the experience of responding to the outbreaks of Ebola virus disease and other diseases had clearly shown the need to establish a new management model and body for WHO's emergency response work and to shift to a comprehensive end-to-end risk management approach. His Government would continue to support the enhancement of WHO's leadership in responding to health emergencies, for instance by supplying national emergency medical teams. The Secretariat should use Member States' expertise effectively and coordinate with nongovernmental organizations and other international organizations in its emergency response work. It should also draw on the experience of mature models and systems, such as those relating to pandemic influenza preparedness, and should ensure science-based assessments. Technical support should be provided to developing countries to strengthen their national health emergency systems and build capacity.

The representative of CÔTE D'IVOIRE said that, despite considerable support from WHO during recent crises, her country continued to face significant challenges with respect to evaluation of the capacity of national health facilities to manage health problems and risks, such as those associated

with the displacement of populations and terrorist attacks. She supported the reforms under way and was in favour of adopting the draft decision.

The representative of AUSTRALIA said that his Government supported the request for an additional US\$ 160 million under the Programme budget 2016–2017. WHO could not succeed in building its emergency preparedness and response capacity or meet international expectations through budget reprioritization. He announced that his Government would contribute Aus\$ 6 million to the WHO Health Emergencies Programme, including Aus\$ 1 million to the Emergency Medical Teams Initiative, and looked forward to further discussions on filling the funding gap. It was important to establish clear lines of authority in order to facilitate rapid decision-making in health emergency situations. The Secretariat should define clear criteria and processes for the timely sharing of information to aid decision-making by the Director-General. At the same time, it should ensure that there was flexibility for regional directors to seek any additional assistance that they required.

The representative of PARAGUAY sought clarification on how the various emergency management activities would be coordinated with countries, with respect for the sovereignty and particular characteristics of each. She also asked about how the WHO Health Emergencies Programme would be integrated with the proposed external evaluations under the International Health Regulations (2005). It was important to ensure the participation of national and regional technical teams and the independent selection of experts from within the region.

The representative of BANGLADESH, commending the Secretariat's efforts to ensure that the emergency management reforms were broad-based and underpinned by strong, collaborative partnerships, said that steps should be taken to enable the Director-General to mobilize the necessary resources. At the same time, care should be taken not to compromise the budget for other important programmes and for routine operations.

The representative of NICARAGUA said that WHO's emergency management capacity could not be strengthened without also strengthening regional and national emergency response capacities. An integrated approach to risk management meant strengthening the leadership of governments and regional institutions in order to optimize emergency response and ensure that it took account of social and cultural characteristics.

The representative of TUNISIA, welcoming the progress made in reforming WHO's work in health emergency management, said that countries should be given greater responsibility in the assessment and management of health risks. The roles of Member States, regional directors and the new Programme's Executive Director must be clearly defined and measures taken to expedite the development of standard operating procedures. Particular emphasis should be placed on training and mobilization of national and regional experts.

The representative of ARGENTINA said that the new Programme was needed to ensure timeliness and predictability in WHO's work in emergency management. Standardized indicators should be used to measure the Programme's performance, and a report on its introduction should be presented to the Executive Board at its 140th session. She supported the proposed increase in the Programme budget 2016–2017 in order to finance the Programme, but would appreciate more information on how the funding would be implemented. It also supported the adoption of the draft decision.

The observer of CHINESE TAIPEI said that Chinese Taipei had drawn on the lessons learned from the outbreak of severe acute respiratory syndrome in 2003 to enhance its emergency response system, including human resources capacity-building, stockpiling of personal protective equipment and budgeting for emergencies. An emergency operations centre had been established and hospitals

had been designated to provide treatment and care to patients with probable or confirmed cases of highly infectious diseases. In support of WHO's emergency management reforms, Chinese Taipei stood ready to join the global partnership to mitigate threats to health security.

The EXECUTIVE DIRECTOR ad interim (Outbreaks and Health Emergencies), expressing appreciation for the supportive and constructive comments, said that the Secretariat was keenly aware of the challenges highlighted by several speakers. The reform process represented a complex task that was being undertaken with the full engagement of all major offices and the three levels of the Organization. With regard to the implementation of the new Programme, 75% of planned additional staffing and financing would be dedicated to the regional and country levels. In line with the burden of disease and outbreaks, 70% of the resources for the regional level would be allocated to the African and Eastern Mediterranean regions, which currently accounted for more than 90% of crisis-affected populations. The Programme would always seek to ensure evidence- and needs-based budget and resource allocation.

Operational planning would be done at the field level, with the Executive Director responsible for ensuring that country and regional offices had the resources they needed for that purpose. Authority with regard to Grade 2 emergencies under the International Health Regulations (2005) would rest initially with the Director-General until a risk assessment had been conducted and it was clear who should be responsible for day-to-day operational oversight. To ensure the sustainability of financing for the new Programme, the Secretariat would organize financing dialogues in June and September 2016 with a view to meeting the immediate financial needs for introducing the Programme and ensuring sustainable resources for the future. Work on resources planning for the biennium 2018–2019 was being done with the regional and country offices. Even though the core budget for emergency management had risen by US\$ 70 million in the Programme budget 2016–2017, that increase had not been sufficient to cover all the additional activities and responsibilities of the Organization under the new Programme.

The members of the Global Policy Group had made it clear that they would proceed immediately with the implementation of new processes and systems to enhance the standardization and predictability of emergency management work across the Organization, and that they would also move forward with restructuring in line with the new functions of the Programme, all of which could be done with minimal funding. However, any further implementation of activities would not be possible without additional resources. The order of priority for activities as resources became available would be: assessment of country vulnerabilities, risk assessments and strengthening of emergency response capacities in the African and Eastern Mediterranean regions. Putting in place health cluster leadership capacity and implementation capacity in priority countries would also take precedence.

With regard to WHO's engagement with the broader humanitarian assistance system, at the forthcoming meeting of the Inter-Agency Standing Committee Principals the Director-General would present a white paper on closer integration and processes for the development of standard operating procedures for biologic hazard response across the United Nations system, recognizing WHO as the lead, as mandated under the International Health Regulations (2005). Consideration had been given to applying a gradual approach to the delivery of the new Programme, first aligning the processes, then the functions, and then ensuring structural alignment. Staffing would be realigned with the new Programme, with any temporary reassignments for acute crises being for a maximum of three months.

With regard to partnerships, the new Programme envisaged a new business model for the Organization that would leverage more systematically the broad range of partners available through the global health emergency workforce, with a view to taking full advantage of expertise available in Member States and ensuring better inter-agency planning and information management. The categorizing and prioritizing of countries was done in line with the International Health Regulations (2005) and WHO's obligations as the health cluster lead agency. Countries were prioritized on the basis of active crises, affected populations and vulnerability as established under the Inter-Agency Standing Committee Index for Risk Management, which used standard criteria for risk assessment for natural disasters and complex emergencies. Another category had been established for biological

hazards, with plans to establish a WHO-led process for categorization on the basis of such hazards. At national level, WHO country offices would prioritize preparedness, implementation of the International Health Regulations (2005) and capacity-building, and work on risk assessment and verification. Influenza was a priority area under the new Programme as one of the main high-threat pathogens that posed a future risk to global health security. He thanked Member States that had pledged financial and in-kind resources for the new Programme.

The CHAIRMAN invited the Committee to consider the draft decision contained in document A69/30.

The draft decision was approved.¹

Implementation of the International Health Regulations (2005): Item 14.1 of the agenda (continued)

- **Annual report on the implementation of the International Health Regulations (2005)** (document A69/20)

WHO response in severe, large-scale emergencies: Item 14.6 of the agenda (document A69/26)

2014 Ebola virus disease outbreak: Item 14.8 of the agenda

- **Options for strengthening information-sharing on diagnostic, preventive and therapeutic products and for enhancing WHO's capacity to facilitate access to these products, including the establishment of a global database, starting with haemorrhagic fevers** (document A69/29)

The CHAIRMAN recalled that the Committee had agreed to consider the first part of item 14.1 of the agenda together with item 14.6 and the second part of item 14.8.

The representative of SRI LANKA, expressing gratitude to WHO and all partners who had supported his country in the wake of the recent emergency caused by tropical cyclone Roanu, said that comprehensive measures had been taken to prepare for and respond to severe, large-scale emergencies, including the enactment of new legislation adopting a multi-hazard approach to disaster management. Efforts were being made to ensure preparedness not only for mass casualty incidents, but also for other types of emergencies, such as infectious disease outbreaks, chemical incidents and radiological and nuclear emergencies. Thanks to its enhanced capacity, Sri Lanka had been able to assist in responding to the earthquake in Nepal in 2015.

The representative of SOUTH AFRICA, referring to agenda item 14.8, said that the international community should continue to support development efforts in the countries affected by the Ebola virus disease outbreak in order to ensure that an outbreak of such magnitude never occurred again. Member States should strive to develop resilient health systems and core capacities in line with the International Health Regulations (2005). South Africa had made progress in strengthening its preparedness and response capacity and was striving to extend its capacities for responding to global health emergencies. Even though several disease-specific research and development databases existed, the Global Observatory on Health Research and Development would be the most suitable option for information-sharing and capacity-building to facilitate access to products for infectious diseases that might cause public health emergencies.

¹ Transmitted to the Health Assembly in the Committee's second report and adopted as decision WHA69(9).

The representative of GUATEMALA, referring to summary of the status and response to the outbreak of Zika virus infection in the Americas (document A69/26, Annex 2), said that Guatemala was exposed to the threat of both infectious diseases and natural disasters. Her Government was working to strengthen its emergency response system: it had opened an emergency operations centre and organized training for emergency response teams. A challenge for the future was to launch a safe hospitals strategy in order to ensure that all health care facilities would remain functional during and after an emergency.

The representative of IRAQ said that WHO country offices should be fully prepared to deal with large-scale emergencies. Capacity-building for surveillance should be enhanced and the Secretariat's support for capacity-building in other sectors should be increased. The role of nongovernmental organizations in health cluster work should be recognized.

The representative of TONGA said that, like many other countries in the Pacific, Tonga was prone to natural disasters and public health events, such as recent outbreaks of Zika virus infection. Progress had been made in improving WHO's response to emergencies and outbreaks, but further effort should be made to enhance countries' emergency response capacities through training to ensure effective leadership during emergencies and disasters. Pacific countries had focused on preparing their health systems to respond to acute events by ensuring that health professionals were able not only to respond to events in their own countries, but also to provide assistance to neighbouring countries.

The representative of MAURITIUS, speaking on agenda item 14.6 on behalf of the Member States of the African Region, said that WHO's capacity for emergency response was constrained by chronic underfunding, lack of human resources, access problems, a limited number of operational partners, logistic difficulties and, in some cases, complicated administrative and clearance processes. The countries of the Region were grateful for WHO's efforts to respond to public health emergencies in Africa, including the Ebola virus disease outbreak. It was, however, crucial to strengthen WHO's capacity in countries with protracted emergencies, in accordance with Sustainable Development Goal 3 on health and its target 3.d for strengthening the capacity of countries for early warning, risk reduction and management of national and global health risks. Consideration should be given to involving the private sector in strengthening emergency preparedness and response, particularly as infectious diseases and other public health events had ramifications for that sector. More investment was needed to build resilient and responsive health systems. A multisectoral approach was also needed. The Secretariat should work with regional institutions in Africa to ensure a coordinated and effective response to large-scale emergencies in the Region and should ensure promptness, predictability, accountability and capability in supporting people affected by emergencies.

The representative of the UNITED REPUBLIC OF TANZANIA, commending the Secretariat for its efforts to support Member States in preparing for potential cases of Ebola virus disease, said that, nevertheless, coordination of actors during emergencies and humanitarian crises should be improved, with WHO taking a leading role in coordinating United Nations agencies and non-State actors.

The representative of the UNITED KINGDOM OF GREAT BRITAIN AND NORTHERN IRELAND, referring to agenda item 14.6, identified the clear need for a "one WHO" approach, with clear lines of accountability, strong links between the health and humanitarian assistance sectors and proper implementation of the International Health Regulations (2005). He urged all Member States to support efforts to control the outbreak of yellow fever in Angola and prevent further spread of the disease to neighbouring countries. In leading the global response, WHO must ensure effective coordination and transparency in its strategic decision-making and clear communication between affected countries and implementing partners. The outbreaks of Zika virus infection and yellow fever had shown that reform of WHO's work in health emergencies response was urgent if the Organization was to be prepared to face future emergencies.

The representative of SENEGAL, speaking on agenda item 14.8 on behalf of the Member States of the African Region, said that more proactive health systems were needed to manage frequent outbreaks of infectious disease in the Region. Operational mechanisms should be put in place to ensure a coherent and synergistic response to epidemics. The creation of the African Centre for Disease Control and Prevention and the establishment of epidemic surveillance and control structures at the subregional and national levels were hopeful developments in that regard. Scientific research and technological innovation should be encouraged under WHO's coordination with a view to facilitating the availability of diagnostic, preventive and therapeutic tools. The Global Observatory on Health Research and Development at WHO had begun its work in January 2016, but there was still a need for global partnerships to provide scientific data and help countries manage health crises.

The representative of KENYA said that his Government had developed a plan and protocols for emergency response, with an intersectoral approach that involved both public and private institutions. It had also established an emergency operations centre to better coordinate preparedness and response. The cost of managing large-scale emergencies was a heavy burden for countries. There was therefore an urgent need to find consistent and sustainable funding sources from both governmental and nongovernmental entities.

The representative of the ISLAMIC REPUBLIC OF IRAN said that implementation of the International Health Regulations (2005) must be a priority if the world was to be prepared to respond to future epidemics. To redress the inequities in global responses, low- and middle-income countries needed strong health systems with capacity for early detection. Rapid response teams were also needed at global, regional and national levels. Simulations and drills should be carried out to identify weaknesses in the performance of health care workers. Research and development of vaccines, medicines and diagnostic tests should be promoted.

The representative of THAILAND said that the yellow fever outbreak in Africa was a classic example of failure to establish the necessary capacity under the International Health Regulations (2005) to detect infections and stop secondary infections in other countries. The lessons learned from the mass displacement of refugees and the Ebola virus disease outbreak should be taken into account in revising the emergency response framework and assessing the funding required. The Secretariat should facilitate further scientific study of Ebola virus disease, in particular the potential for transmission during its asymptomatic, subclinical and recovery phases and the immunological response during the period of infection. Such research would provide information for the development of effective vaccines and diagnostic and therapeutic products. He commended WHO's contribution to the development of Ebola vaccine candidates. He urged the de-linking of research and development from intellectual property protection and requested the Director-General to do her utmost to ensure access to such necessary medical products in areas where resources were limited.

The representative of INDONESIA said that efforts to strengthen cooperation for the prevention and control of haemorrhagic fevers, including the sharing of information on for instance diagnostics, prevention and therapy, were of prime importance. She welcomed the action taken by the Secretariat to facilitate such information sharing through the Global Observatory on Health Research and Development. Further development of that platform should be carried out in consultation with Member States.

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

The meeting rose at 17:15.

SIXTH MEETING

Wednesday, 25 May 2016, at 18:40

Chairman: Ms T. KOIVISTO (Finland)

PREPAREDNESS, SURVEILLANCE AND RESPONSE: Item 14 of the agenda (continued)

Pandemic influenza preparedness: sharing of influenza viruses and access to vaccines and other benefits: Item 14.2 of the agenda (documents A69/22, A69/22 Add.1 and A69/22 Add.2)

The CHAIR OF THE PANDEMIC INFLUENZA PREPAREDNESS FRAMEWORK REVIEW GROUP, introducing the Review Group's first review of the Pandemic Influenza Preparedness (PIP) Framework in 2016 (document A69/22 Add.2, Annex 2), noted that recent outbreaks of communicable diseases including influenza had underscored the vulnerability of many countries to public health emergencies that threatened global health security. The emergence of another influenza pandemic was inevitable, and Member State preparedness was therefore vital. The Review Group had sought answers to questions about the achievements of the PIP Framework, whether it had helped the world to prepare for a pandemic, and what were the challenges and possible solutions.

The Review Group had already held teleconferences and face-to-face meetings with Member States and other stakeholders and conducted interviews with key informants. Information received thus far showed that implementation was proceeding steadily and effectively and all stakeholders had worked together to improve global preparedness for an influenza pandemic. Industry manufacturers had paid 95% of partnership contributions and WHO had secured advance access to three times more pandemic vaccines and antiviral agents than in 2009, through Standard Material Transfer Agreements 2. She described ongoing capacity-building activities under the PIP Framework, including: the detection, monitoring and sharing of viruses with pandemic potential; analysing and sharing viruses for risk assessment; disease burden studies; strengthening regulatory capacity; planning for deployment of pandemic supplies; and efficient risk communication during a pandemic. The PIP Framework had received extraordinary commitment from: Member States, which continued to provide financial and political support to the essential work of public health laboratories; industry, which had contributed funding and provided real-time access to life-saving pandemic vaccines and other pandemic material; and civil society, which had contributed to discussions on how to strengthen the initiative. WHO's Global Influenza Surveillance and Response System was the backbone of the PIP Framework and Member States should ensure the systematic and timely sharing of all viruses with pandemic potential in that System for essential risk assessment. The benefit-sharing mechanism had demonstrated its effectiveness, although it faced the challenges of real-world implementation, including barriers to the timely shipping of viruses. Clues to the emergence of the next pandemic virus could be missed if viruses were not shared in the Global Influenza Surveillance and Response System. Payment of partnership contributions must continue or improve as the sustainability of the system required equity and fairness.

The Review Group had considered goals and processes shared with other WHO programmes and instruments such as the International Health Regulations (2005) and the Global Action Plan for Influenza Vaccines, noting the relevance of the IHR Review Committee recommendation on sharing of genetic sequence data. Some of the important work under the Global Action Plan for Influenza Vaccines could continue after its conclusion. It remained to be seen whether the PIP Framework or the Global Influenza Surveillance and Response System could or should be considered specialized

instruments under the Nagoya Protocol on Access to Genetic Resources and the Fair and Equitable Sharing of Benefits Arising from their Utilization to the Convention on Biological Diversity. The Review Group was monitoring the situation through the PIP Framework secretariat acknowledging the mandate of that body to study the potential public health implications of the Nagoya Protocol and make appropriate recommendations.

Pandemic preparedness required solidarity between Member States, industry, public health laboratories, civil society and donors. The PIP Framework worked with all stakeholders and was therefore a model for cooperation.

Ensuring that the PIP Framework remained relevant was an overarching issue, given the difficulty in maintaining focus on one disease against competing public health emergencies. Pandemic influenza preparedness supported global preparedness for other communicable diseases and the PIP Framework was likely to provide several indirect benefits including ongoing projects in Member States. Successful preliminary outcomes had driven discussions on expanding the PIP Framework to include seasonal influenza, which would have implications for the Framework, and on using it as a model for other infectious pathogens. Influenza viruses caused seasonal and epidemic outbreaks and were a constant pandemic threat. Viruses were studied seasonally for pathogenicity, transmissibility and population immunity to assess risk, and pandemic vaccine production capacity was based on sufficient seasonal vaccine production capacity. Several linkages therefore supported expanding the Framework to all influenza viruses posing a risk to human health, provided that did not overburden the Global Influenza Surveillance and Response System laboratory network and the implications for benefit-sharing implications were assessed. Expanding the PIP Framework to other pathogens or using it as a model for the sharing of other pathogens was an interesting but complicated option that raised considerable challenges. The Review Group had instead highlighted principles that could be shared, such as that of equal footing, and discussions on accounting for the specific characteristics of specific pathogens.

Genetic sequence data had assumed an increasingly prominent role in influenza research and vaccine production owing to advances in genomics. Broad discussions had been held with industry, genetic database holders and civil society to decide how best to handle genetic sequence data under the PIP Framework. The PIP Advisory Group would assess the work done and attempt to offer a way forward on the issue. Health crises were unavoidable and affected vulnerable populations. It was therefore crucial that countries establish systems, practices and procedures to ensure equitable access to life-saving supplies; that the weakest countries received support to strengthen capacities to prepare for and respond to public health emergencies; that the world was prepared for health emergencies; and that the Review Group received stakeholder input to ensure successes and challenges were understood.

The representative of CHINA commended the Organization's efforts to promote the PIP Framework and described steps taken in his country to implement it, including the signing of a Standard Material Transfer Agreement and sharing of viruses and information.

The representative of BRAZIL said that recent cases of pandemic influenza A(H1N1) in Brazil had exemplified the importance of an effective PIP Framework, particularly in sharing influenza virus strains. The PIP Framework had been successful in enabling the sharing of virus samples and benefits on an equal footing and establishing a positive, dynamic relationship between the public and private sectors. The PIP Framework review should be comprehensive, transparent and independent, and involve Member States, to assess successes and areas for improvement. Implementation of the PIP Framework must adapt to technological changes. It was gratifying that the Review Group prioritized the equal footing principle and was studying the evolving aspects of technology, particularly genetic sequence data of viruses. The PIP Framework and other mechanisms should apply to new genetic sequencing methodologies and treat them as material biological samples.

The representative of SOUTH AFRICA said that partnership contributions had helped target countries to develop capacities to detect and monitor novel influenza and other respiratory pathogens. She commended WHO's promotion of the expansion of global seasonal influenza vaccine production and called on the Organization to continue its leadership in facilitating new technologies and research to ensure the required number of doses. She commended also production agreements reached with vaccine manufacturers, progress towards a web portal, and financial and technical data reporting. However, few members of target populations in low- and middle-income countries could afford influenza vaccines. As high influenza vaccine coverage was important for pandemic preparedness, it was vital that all Member States implemented measures to fulfil the requirements under the PIP Framework. Her Government was committed to strengthening the Global Influenza Surveillance and Response System.

The representative of VIET NAM appreciated the support provided to developing countries to increase influenza vaccine production capacity through access to technology; that should continue under the PIP Framework. Sample-sharing mechanisms needed to be reviewed, as did the right of countries to consult on the use of samples and to assess influenza virus mutations. WHO should provide information on influenza vaccine efficacy and safety, prepare vaccine stockpiles and prioritize high-risk countries. He described steps taken by his country to prepare for pandemic influenza, including vaccine development and surveillance.

The representative of the ISLAMIC REPUBLIC OF IRAN expressed concern that disbanding the Global Influenza Surveillance and Response System and grouping influenza with other diseases with pandemic potential would jeopardize any pandemic or seasonal influenza response. He encouraged WHO to recognize the System's value in mitigating seasonal influenza and events during an influenza pandemic. His country acknowledged the Organization's support in influenza vaccine production; however, it needed more technical assistance to complete that process. The Secretariat should more effectively engage countries with good surveillance and response capacities and contribute to burden estimation and surveillance studies supporting vaccine production and response assessment.

The representative of IRAQ called for epidemiological surveillance to be fully integrated into laboratory surveillance. WHO should facilitate the exchange of expertise within and between regions. He also requested that focus be placed on the Organization's role in joint research and the development of national action plans; ensuring the sustainability of materials and other requirements for influenza prevention and control and facilitating the incorporation of pandemic preparedness into primary health care.

The representative of JAPAN said that timely sample sharing was essential to ensure a prompt response to a global influenza pandemic. The PIP Framework had recently played a vital role to that end. The Secretariat, the PIP Framework Advisory Group and other relevant bodies needed to analyse and monitor outcomes and allocations of partnership contributions to ensure their appropriate and effective use in line with the Advisory Group's recommendations. Sharing data in the spirit of the PIP Framework was important, although genetic sequence data needed to be handled with special caution. The Secretariat and the Advisory Group should strive for greater transparency and fairness in their leadership, and in that context should continue consultations with Member States and relevant industries. The 2016 PIP Framework review would ensure the efficiency and effectiveness of that Framework, which should be aligned with WHO's other emergency programmes. WHO should focus on seasonal influenza preparedness as the foundation of pandemic preparedness. The PIP Framework and the Global Influenza Surveillance and Response System should be fully integrated into the new WHO Health Emergencies Programme.

The representative of the DOMINICAN REPUBLIC said that the Review Group's recommendations would require open access to genetic sequence data without undue restrictions for scientific research. The products and benefits of genetic sequence data should also be shared. He described recent steps taken by his country to implement the PIP Framework, including exchanging genetic sequence data through the FluNet platform and working with PAHO to improve the application of new case definitions. He emphasized the relationship between the PIP Framework and the International Health Regulations (2005) and, recognizing that developing countries required the Organization's support to strengthen laboratory, surveillance and monitoring capacities, he welcomed the scheduled visit to his country.

The representative of BAHRAIN said that the reports reflected the progress made in the fight against pandemic influenza. He described measures implemented in his country to reinforce pandemic influenza preparedness and strengthen laboratory capacity, including the establishment of a National Influenza Centre to promote virus and benefit sharing.

The representative of the REPUBLIC OF KOREA acknowledged the Secretariat's effort to strengthen pandemic influenza preparedness and response. His country contributed to virus sharing, but stronger advocacy for Standard Material Transfer Agreements 2 was needed to ensure that standard materials were delivered transparently and efficiently.

The representative of PARAGUAY acknowledged the PIP Framework's relevance for her country and its surveillance system, given the latent risk of a potential influenza pandemic. Continued support from the Secretariat was therefore crucial for laboratory and surveillance capacity-building. Support was needed to incorporate virus sequencing and monitoring of antiviral drug resistance as routine practice in countries without that infrastructure. Regional strategies for the exchange of influenza viruses with pandemic potential should be strengthened, and flexible and secure strain-exchange mechanisms were needed. Ensuring access to vaccines in future pandemics was vital, particularly in countries with small populations. This required flexible financing mechanisms, especially in developing countries. Surveillance systems should be continuously improved and assessed by a team of international experts, one of whom should originate from the Region of the Americas given the similar needs of countries in the region.

The representative of EGYPT said that as developing countries were most affected by seasonal influenza epidemics, the Secretariat should increase technical and financial support to those countries by implementing the PIP Framework, improving sustainability and laboratory capacity to analyse genetic sequence data, introducing new technologies, providing competent staff, enacting vaccine policy, and ensuring cost effectiveness. Given the lack of knowledge of the PIP Framework among smaller vaccine manufacturers, WHO should strengthen its PIP Framework advocacy plan, which her Government would support. She asked whether vaccine stockpiles were sufficient to cover upcoming influenza seasons and potential pandemics, and how the fair distribution of vaccines would be monitored.

The representative of PANAMA expressed her country's commitment to national capacity-building in preparedness and response to potential high-risk public health events and implementing the global action plan on antimicrobial resistance. She acknowledged the technical support from WHO and other agencies. Countries needed to promote the health of migrants, despite the latter's difficult situation. Timely response to their health needs, especially among irregular migrants, required resources at all levels and better monitoring from United Nations specialized agencies.

The representative of THAILAND recommended extending the PIP Framework and benefit sharing to cover seasonal and potential pandemic influenza viruses. Partnership contributions should be increased from the current 50% of the running costs of the Global Influenza Surveillance and

Response System, according to inflation and annual running costs; extended to cover research and development bodies that use and benefit from biological materials; and used to strengthen seasonal influenza vaccine production capacities in developing countries.

The representative of MEXICO commended the information provided on the work of the PIP Framework, and praised the wide variety of approaches discussed, particularly innovative partnerships with the private sector. He urged countries to continue cooperating with the Secretariat to strengthen epidemiological surveillance capacities to ensure viruses were efficiently identified in the event of pandemic.

The representative of CANADA said that future implementation of the PIP Framework would be affected by issues such as the handling of genetic sequence data, new technologies and linkages with the International Health Regulations (2005) and other global agreements. The outcomes from the 2016 review would inform future efforts, particularly on genetic sequence data of virus samples and benefit sharing, and improve global implementation of the PIP Framework while considering virus sharing realities.

The representative of SWAZILAND, speaking on behalf of the Member States of the African Region, acknowledged the consultative review of the PIP Framework. He endorsed the financial report on the use of partnership contributions, and welcomed the allocation of 70% of those contributions to building laboratory and surveillance capacities, which would enhance detection and monitoring capacities for influenza and other respiratory viruses. Countries would therefore be able to report to WHO using virological and epidemiological data from event-based surveillance. Despite the designation of national influenza centres in Zambia and the United Republic of Tanzania, significant geographical and funding gaps remained a challenge in the Region. He appreciated the increase in global vaccine production capacity; the number of developing countries with approved vaccines; and the availability of dose-sparing technologies. Public-private partnerships and agreements with other academic and research institutions under the PIP Framework provided access to vaccines, antiviral agents and other pandemic material. Information on the PIP Framework should be shared with all stakeholders. Vaccine-related genetic sequence data should be widely shared; however, Member States should also consider regulatory matters and intellectual property, monitoring methods, biosecurity and biosafety. All countries in the Region remained committed to influenza monitoring and surveillance, enhancing preparedness, further harmonization with existing mechanisms at all levels, and continued advocacy to strengthen preparedness, sharing of influenza viruses and access to vaccines and other benefits.

The representative of INDONESIA praised the level of support provided through partnership contributions to improve event-based epidemiological and virological surveillance and maintain key achievements and capacities. Recipient countries should also develop exit strategies to ensure sustainability of national capacity. She expressed concern that projected global vaccine production capacity would not meet requirements in the event of a pandemic and urged the Director-General to encourage the sharing of benefits, including technology, to improve production capacity. She appreciated efforts made by the PIP Framework Secretariat to negotiate with international influenza vaccine manufacturers and diagnostic companies to ensure global protection in an influenza pandemic. All Member States should comply with all PIP Framework mechanisms, and the 2016 review should be fair, transparent and equitable. She reiterated the importance of including the sharing of genetic sequence data of viruses in the PIP Framework.

The representative of the RUSSIAN FEDERATION noted the significant progress made through the implementation of the PIP Framework, including increased laboratory capacity at the global and national levels through the expansion of the WHO reference laboratory network and increased global influenza vaccine production capacity. Research into innovative influenza vaccines

should be augmented. Work on the conclusion of agreements to allow developing countries access to vaccines and antiviral agents had intensified; WHO's experts and legal consultants should help to encourage manufacturers to sign Standard Material Transfer Agreements. It was important that WHO's Technical Working Group promptly complete its guidance on optimal characteristics for a genetic sequence data sharing system, which could potentially be used to manufacture vaccines and other products. The guidance should consider legal and scientific aspects and the consequences for public health and the biosecurity of new developments in synthetic biology linked to the creation and use of influenza viruses with pandemic potential. She underscored the need for a more thorough, transparent and inclusive analysis of the implementation of the PIP Framework by the Review Group and supported the Advisory Group's recommendations to the Director-General on the scope and terms of reference for the 2016 review.

The representative of the UNITED STATES OF AMERICA noted that some countries and national influenza centres were experiencing a lack of funding and government commitment. She urged WHO and its partners to continue prioritizing global influenza preparedness and response, which had proved vital to collective global health security efforts. Her Government would continue to collaborate with the Secretariat to strengthen the PIP Framework in areas such as genetic sequence data handling and harmonizing the PIP Framework with existing global health instruments. She commended the multistakeholder consultation undertaken as part of the 2016 review.

The representative of the UNITED REPUBLIC OF TANZANIA said that, although partnership contribution funds received by her country had been directed at strengthening influenza response, surveillance and response systems had been strengthened overall. The Review Group should consider how to increase awareness of the PIP Framework so it could be effectively implemented alongside other initiatives including the Global Health Security Agenda. It should address the slow funding flow which led to delays in workplan activities in some countries, and consider expanding the PIP Framework model to include other infectious diseases.

The representative of TUNISIA noted the efforts to conclude agreements with producers of genetic material. The role of WHO under the PIP Framework should be to strengthen national laboratory capacities, particularly the level of security under which virological analyses were undertaken, and to equip laboratories with new technologies such as those for genetic sequencing. It was also important to carry out research on the influenza disease burden to design effective national vaccination policies. WHO regional offices should continue to provide support to national efforts.

The representative of ZAMBIA noted the different measures taken by her Government to combat influenza, including the designation of a National Influenza Centre and a strengthened surveillance system. Recognizing the ongoing review of the PIP Framework, she expressed support for that Framework.

The observer of CHINESE TAIPEI said that the PIP Framework should be the basis for addressing novel and seasonal strains of the influenza virus and the sharing of viruses and other materials on an equal footing, and urged all partners to support it. Chinese Taipei would respond to future outbreaks by increasing vaccination coverage and production capacity.

The representative of the WORLD MEDICAL ASSOCIATION, speaking at the invitation of the CHAIRMAN, recognized the many concerns that arose during influenza outbreaks and said that physicians should have access to reliable information through pre-established channels. All stakeholders should be involved in the development of national preparedness plans, with governments ensuring access to vaccines, and health-care professionals delivering frontline services. Health system strengthening was essential, as the provision of all health services should be maintained even during

an outbreak. Lessons should be learned from the Ebola virus disease epidemic on patient management and the need for deaths to be investigated.

The EXECUTIVE DIRECTOR ad interim (Outbreaks and Health Emergencies) welcomed Member States' support for the PIP Framework and thanked the Chair of the Review Group for her work. The Secretariat was actively engaged in advocacy for further Standard Material Transfer Agreements 2 and had already assigned four vaccine manufacturers, 41 academic research institutes and one diagnostic producer, with a further seven agreements being considered. He dispelled the rumour about the disbandment of the Global Influenza Surveillance and Response System as untrue; WHO greatly valued its significance and would continue to ensure its central role. He noted the requests for a range of technical assistance from the Organization on the burden of disease, vaccine production and access to new technologies. With regard to transparency, the Advisory Group had webcast its proceedings, met face-to-face with missions and rapidly produced reports, but WHO welcomed any further suggestions for improvement. In relation to the quantity of vaccines available for pandemic influenza, he recognized that substantially more was available than 10 years previously, but that quantity was still not sufficient. Work would continue on increasing the proportion of the vaccine available to WHO and on ensuring it could go further, for instance, through dose-sparing approaches. Handling genetic sequence data was a complex issue but one of central importance on which progress would be made.

The Committee noted the reports.

Smallpox eradication: destruction of variola virus stocks: Item 14.3 of the agenda (document A69/23)

The representative of EGYPT said that a deadline had still not been set for destruction of variola virus stocks, despite the convening of a Scientific Working Group and an Independent Advisory Group on public health implications of synthetic biology technologies related to smallpox to provide evidence for that decision to be made. Given that WHO's guidelines prohibited the use of a recreated variola virus in the development of diagnostics and vaccines, it was absolutely mandatory that existing stocks be destroyed. As the completion and review of ongoing projects on antiviral agents against smallpox would take three years, the deadline for destruction of existing stocks should be established as quickly as possible.

The representative of THAILAND said that strengthening public health emergency preparedness and response, including ensuring vaccine supply, was the first line of defence against any emerging disease outbreaks and against bioterrorism. She noted with concern the delay in agreeing a deadline for the destruction of existing variola virus stocks and requested that the issue be discussed at the Seventieth World Health Assembly. Manufacturers of smallpox vaccines should be obliged to contribute to the global stockpile. It was also important to apply the lessons learned from the PIP Framework to pandemic smallpox preparedness.

The representative of AUSTRALIA said that his Government supported the recommendation to enhance the technical capacity of the WHO Advisory Committee on Variola Virus Research to include new technologies and synthetic biology, and commended the review of WHO's recommendations concerning the synthesis and use of variola virus DNA. Carefully managed stocks of live variola virus should be retained for the further development of countermeasures and caution should be exercised in making a decision on the destruction of those stocks. He supported the proposal to include a substantive item on the destruction of variola virus stocks on the provisional agenda of the Seventy-second World Health Assembly.

The representative of NAMIBIA, speaking on behalf of the Member States of the African Region, expressed concern at the repeated delays in setting a date for the destruction of existing variola virus stocks, despite previous agreement. She sought assurance that no undue risks would arise from that delay, and requested ongoing reporting on inspections of the variola virus repositories. In light of the evolving nature of the risk of re-emergence of smallpox, she urged WHO to investigate reports of the re-emergence of monkeypox in Africa, which could impact ongoing research. She welcomed the proposal to include members with appropriate expertise in new technologies on the Advisory Committee and the recommendation that three years be granted to complete ongoing research projects.

The representative of the RUSSIAN FEDERATION supported continued work to create a mechanism for rapid access to WHO's emergency stockpile of smallpox vaccine, but said that discussions should be conducted more openly. He noted that the question of whether WHO should establish an emergency stockpile of antiviral agents for treatment of smallpox remained open. The variola virus stocks held in the Russian Federation had been used to produce means for diagnosing, preventing and treating smallpox, which could be supplied to WHO if required. He supported the conclusions and recommendations of the Advisory Committee at its 17th meeting, including the need to create a network of laboratories dealing with smallpox diagnostics that did not need live variola virus and to expand expert knowledge in the fields of laboratory biosecurity and diagnostics. The terms of reference of the Advisory Committee were sufficiently broad to include the area of synthetic biology technology. If the Advisory Committee decided to recruit additional members with expertise in new technologies, the Russian Federation would put forward a candidate.

The representative of the UNITED STATES OF AMERICA noted that, given the implications of the advances in biotechnology for the synthesis and even genetic modification of variola virus, the Independent Advisory Group had concluded that the destruction of variola virus stocks could no longer be considered irrevocable. In that light, changes should be made to preparedness and response plans. All appropriate research should be completed prior to any decision on destruction of stocks. Therefore, the Advisory Committee should immediately consider new research to protect against the risk that the variola virus could be synthetically created, altered or misused. Additional experts in the fields of synthetic biology and emerging biotechnology should be added to the Advisory Committee. The Health Assembly should reconsider the destruction of variola virus stocks in five years, or whenever it warranted revisiting. His Government welcomed the biennial inspections of the two WHO repository laboratories, and the transparent nature of inspection reports.

The representative of NORWAY said that his Government would not support a decision on the destruction of variola virus stocks at the current Health Assembly. Given the need to further study the implications of synthetic biology relating to smallpox, he was in favour of including smallpox and the destruction of variola virus stocks on the provisional agenda of the Seventy-second World Health Assembly.

The representative of IRAQ said that all research should continue under the sponsorship of WHO, in order to ensure progress towards global health security.

The representative of GEORGIA stressed that smallpox remained a threat to the global community as vaccination campaigns had ceased and variola virus genetic sequencing had been completed. Public health preparedness should be strengthened by including synthetic biologists in the Advisory Committee, and by improving diagnostics and treatment. Existing variola virus stocks should be maintained in the repositories for the development of new countermeasures. WHO should conduct a review in five years – or whenever research goals or new developments warranted – to allow time for researchers to complete their work and for the Advisory Committee consider that new

research. At the current time, he opposed the destruction of variola virus stocks, but said that his Government would continue to work with the Secretariat and Member States on the issue.

The representative of CANADA recognized the limited value of retaining stocks of variola virus but acknowledged that security concerns remained, particularly owing to developments in synthetic biology. The Director-General should seriously consider the recommendations of the Independent Advisory Group and the Advisory Committee, and the latter should continue to consider the implications of synthetic biology. Her Government supported the inspections of declared stocks, including the provision of technical experts as needed, and she looked forward to receiving the reports on the variola virus repositories.

The representative of ARGENTINA noted the Independent Advisory Group's recommendations on the need for increased preparedness and knowledge of biosafety and biosecurity given the possible synthesis and re-emergence of the variola virus. The Advisory Committee needed more expertise on new biotechnologies and synthetic biology, and should expand its field of inquiry before considering the destruction of existing variola virus stocks.

The representative of the ISLAMIC REPUBLIC OF IRAN recalled decision WHA64(11) (2011) on smallpox eradication: destruction of variola virus stocks and the three separate deadlines that had been set by the Health Assembly for destroying remaining variola virus stocks, none of which had been met. All necessary research requiring live variola virus had been completed and any further studies would be of limited benefit to public health. WHO should therefore exercise leadership in destroying the remaining stocks, end authorization for new research involving the live variola virus, and guarantee universal and equitable access to all existing research outcomes. Genetic engineering of the variola virus must be prohibited and enforcement strictly monitored. Developments in synthetic biology did not change the fact that stocks should be destroyed, nor did the recommendation to revise the current rules on the use of synthetic material. WHO must immediately set a deadline for the destruction of variola virus stocks.

The representative of INDONESIA strongly supported the decision to destroy remaining variola virus stocks in order to ensure global health security. Given the importance of biosafety and biosecurity in the destruction process, WHO must provide support for a global notification system. He asked WHO to develop recommendations on synthetic biology technologies and assured the Health Assembly that no Indonesian institution would stock variola virus.

The representative of the REPUBLIC OF KOREA recognized that advances in synthetic biology had increased the risk that smallpox would re-emerge. More research in that area, as well as on diagnostic tests, animal models, new vaccines and antiviral agents would be needed, but prevention and response must remain priorities. Immediate destruction of variola virus stocks could reduce response capacities: a better decision could be made in four to five years, once sufficient research had been done. His Government would seek to incorporate the revised biosafety rules into national biosafety regulations.

The representative of CHINA noted that good progress had been made in the development of early and rapid diagnostic methods, antiviral agents and new vaccines, which had led to the development of important safeguards. The pressing issue was how effectively to prevent the re-emergence of smallpox. She supported completion of experiments with live variola virus as soon as possible, quickly reaching a consensus on destroying stocks and strictly prohibiting the synthesis of variola virus.

The representative of JAPAN, while sharing commitment to the goal of destroying variola virus stocks, supported continued research in order to develop countermeasures to a potential synthetic or

enhanced strain of virus, given the serious risk of its use for bioterrorism. Appropriate experts should be included on the Advisory Committee. Progress should be reviewed in a timely and appropriate manner, but with flexibility on the timing of the next review. A balanced approach would be required when deciding on the destruction of remaining variola virus stocks.

The representative of the UNITED KINGDOM OF GREAT BRITAIN AND NORTHERN IRELAND stressed the need to complete ongoing research and further consider the implications of synthetic biology before the Health Assembly discussed the destruction of variola virus stocks, although that discussion should be held within a maximum period of 5 years. She agreed that members with expertise on emerging biotechnologies and synthetic biology should be added to the Advisory Committee.

The EXECUTIVE DIRECTOR ad interim (Outbreaks and Health Emergencies) assured Member States that the forthcoming repository inspection reports would be made available on the WHO website. He noted the comments welcoming the addition of new members with expertise on emerging biotechnologies to the Advisory Committee. Although the Secretariat had proposed not to reopen discussion on destruction of variola virus stocks until the Seventy-second World Health Assembly in 2019, the Advisory Committee would nonetheless continue to meet annually, and repositories would still be inspected biennially. Recognizing the divergent views on when next to review the issue, he said the Secretariat's proposal of three years provided a middle ground and hoped it would be acceptable to the Health Assembly.

The representative of THAILAND said that her proposal of including a substantive item on smallpox on the provisional agenda of the Seventieth rather than the Seventy-second World Health Assembly had not been formally accepted or rejected. Waiting more than 1 year between reviews would put the world at greater risk. An alternative would be to include an annual progress report instead of a substantive item.

The DIRECTOR-GENERAL said that if new members were to be added to the Advisory Committee as requested, 1 year may not be enough time to deliver sufficient results to report back to the Health Assembly. She urged that a timeline of 3 years should be sufficient.

The representative of EGYPT supported the proposal made by the representative of Thailand. As the Advisory Committee met annually and the repositories were inspected every 2 years, there should be sufficient material for an annual report to the Health Assembly.

The representative of the UNITED STATES OF AMERICA, agreeing with the comments made by the representatives of Thailand and Egypt, noted that an annual progress report on smallpox was always submitted to the Health Assembly.

The representative of the ISLAMIC REPUBLIC OF IRAN agreed that a progress report should be submitted annually to keep the issue current and enable evidence-based decisions.

The EXECUTIVE DIRECTOR ad interim (Outbreaks and Health Emergencies) said that it was clear that Member States favoured the submission of annual progress reports and the inclusion of a substantive agenda item as appropriate based on that progress.

The CHAIRMAN said that she took it that the Committee noted the report and agreed that annual progress reports should be submitted to the Health Assembly and that a substantive agenda item should be included on the provisional agenda of the Seventy-second World Health Assembly.

It was so agreed.

Global action plan on antimicrobial resistance: Item 14.4 of the agenda (documents A69/24 and A69/24 Add.1)

The representative of SRI LANKA supported the establishment of a global framework on antimicrobial resistance, but said that the growing use of antimicrobials in agriculture and veterinary medicine posed serious challenges, as did their illegal production and availability without prescriptions. The public must be made aware of the consequences of antimicrobial resistance for the future treatment of infectious diseases; empowering communities would help to limit illegal production and indiscriminate use. Prescription practices should be monitored to ensure adherence to national policies. The WHO Model List of Essential Medicines should not limit the number of medicines but allow a choice while still observing antibiotic policies. WHO should provide leadership in bringing together stakeholders so the problem could be attacked from all sides.

The representative of the NETHERLANDS, speaking on behalf of the European Union and its Member States, said that the candidate countries Turkey, the former Yugoslav Republic of Macedonia, Serbia and Albania, the country of the Stabilization and Association Process and potential candidate Bosnia and Herzegovina, as well as Ukraine, the Republic of Moldova and Georgia aligned themselves with her statement. Combatting antimicrobial resistance required concerted multisectoral action at all levels. The global action plan on antimicrobial resistance represented an important global consensus on action needed to combat antimicrobial resistance. Commending WHO's support for the development of national action plans, she welcomed work towards a global development and stewardship framework, which was vital to ensure that the issues of stewardship, innovation and access were balanced and should continue under WHO leadership with support from relevant actors. However, more concrete options for establishing the framework were needed, such as the development of a global prioritized list of antibiotics and the identification of research and development needs. She encouraged the Director-General to continue engaging with the United Nations Secretary-General to prepare for the United Nations General Assembly High-level Meeting on antimicrobial resistance, an event that called for active preparation and coordination from Member States and should be the basis of further work across United Nations agencies. She looked forward to proposals for future action following that Meeting.

The representative of PARAGUAY described measures to combat antimicrobial resistance in her country, including a network of public and private laboratories monitoring antimicrobial resistance, inclusion of the subject in medical and veterinary education, and training in infection prevention and control. Technical support was needed from WHO to develop and monitor a national action plan, improve regulation of medicines, and develop mechanisms ensuring access to antimicrobials and other materials. The time frame mentioned in the global action plan on antimicrobial resistance should be extended to allow strategies and interventions to be fine-tuned and to ensure sustainable short- and medium-term results in all countries.

The representative of the UNITED REPUBLIC OF TANZANIA, noting efforts to develop a national action plan on antimicrobial resistance, supported efforts by WHO, FAO and OIE to develop a global package of activities to combat antimicrobial resistance under the global action plan. He encouraged countries that had not yet done so to make use of the flexibilities under the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) in order to facilitate local production. He urged WHO to provide an effective international mechanism for exchange of data on antimicrobial resistance, to be linked with WHO's Global Observatory on Health Research and Development. Outcomes from the United Nations General Assembly High-level Meeting on antimicrobial resistance should boost the implementation of the global action plan by the Secretariat and Member States.

The representative of SENEGAL provided details on antimicrobial resistance measures implemented in his country, in particular the creation of a national list of bacteria susceptible to

resistance, sensitivity testing of those bacteria, and expansion of antimicrobial surveillance to include animal health. He encouraged the implementation of the “One Health” initiative in the fight against antimicrobial resistance.

The representative of the PHILIPPINES described measures adopted in the country’s national action plan, which included multisectoral policies, national guidelines and programmes for the rational use of antimicrobial medicines and infection prevention and control, as well as research and development of new technologies. She supported the development of a global priority list of antibiotics under a global stewardship framework; but encouraged further consideration of awareness-raising and training, professional codes, regulatory mechanisms and funding mechanisms to subsidize essential antibiotics for poorer populations.

The representative of IRAQ called for emphasis on supporting laboratory surveillance; considering epidemiological and demographic variables; developing an action plan on sentinel sites; and joint monitoring and assessment of national action plans on antimicrobial resistance. The Organization’s role in the capacity-building of staff and institutions should be strengthened, as should WHO country offices.

The representative of KENYA said that the burden posed by antimicrobial resistance required collective political, financial and technical commitment and support from WHO and other partners. He described steps taken in his country to combat antimicrobial resistance, with particular reference to multisectoral efforts at the national level to analyse the situation, to develop national policies and bodies on antimicrobial resistance, and to regulate the quality of antimicrobial medicines on sale. He reiterated the importance of involving Member States and all other stakeholders in the development of a balanced global development and stewardship framework. All Member States should develop and implement strong surveillance systems to detect antimicrobial resistance and foster collaboration and information exchange to combat it.

The representative of the UNITED KINGDOM OF GREAT BRITAIN AND NORTHERN IRELAND said that commitments made at the United Nations General Assembly High-level Meeting on antimicrobial resistance should accelerate implementation of the global action plan and the development of national action plans. Her Government would continue to work towards consensus on a global financing solution to address the causes of antibiotic market failure, and had pledged £265 million to improve laboratory capacity, diagnosis and antimicrobial resistance data and surveillance in low- and middle-income countries. She supported the call for the Director-General to update the United Nations Secretary-General on work done on the stewardship framework and to report the outcomes of the High-level Meeting and the Secretariat’s recommendations for next steps to the Executive Board at its 140th session. Although WHO would still lead on health aspects, the approach taken to antimicrobial resistance enabled greater engagement with other United Nations agencies including FAO, OIE and WTO, and so care should be taken in preparing for the High-level Meeting.

The representative of ICELAND drew attention to the reference to contaminated food as an important route of transmission of antimicrobial-resistant bacteria in view of a recent document published by the European Centre for Disease Prevention and Control and the European Food Safety Authority. He supported the Organization’s efforts to combat the spread of antimicrobial-resistant bacteria through, inter alia, reducing the use of antimicrobial medicines in humans and animals and improving surveillance, diagnostics and public awareness of bacterial contamination and hygiene.

The representative of SOUTH AFRICA, recalling that stewardship could be seen as the responsible management of antimicrobials to improve patient outcomes while minimizing the development of resistance, said that a balanced stewardship framework was required, with input from

FAO, OIE and industry stakeholders. A review of the WHO Model List of Essential Medicines was necessary to identify those antibiotics that should always be available and those that should be reserved for targeted use. Restricting the use of second-line antimicrobial medicines to cases demonstrating confirmed first-line treatment failure could be the key to preventing widespread resistance.

The representative of GERMANY underlined the importance of the development of national action plans by Member States for the timely implementation of the global action plan on antimicrobial resistance, such as the plan adopted by her Government. Her Government would contribute €1.3 million for the implementation of the global action plan in 2016. The United Nations General Assembly High-level Meeting would increase awareness at the highest political level and she encouraged WHO to continue its leadership on the health aspects of antimicrobial resistance. Given the need to strengthen research, her Government would provide an additional €500 000 to the recently-launched Global Antibiotic Research and Development Partnership between WHO and the Drugs for Neglected Diseases initiative and she encouraged others to do the same.

The representative of BRAZIL, noting that the complexity of antimicrobial resistance deserved serious reflection, said that WHO was in a position to contribute substantially to the United Nations General Assembly High-level Meeting. Brazil had adopted measures to ensure the rational use of medicines and multisectoral action based on the global action plan. As many countries were still formulating national action plans, ongoing discussions on options for a global stewardship and development framework must not duplicate the global action plan. He emphasized that the “One Health” initiative did not mean that one size fit all, and encouraged WHO, FAO and OIE to continue working within their respective mandates and commitments. Monitoring, control and conservation of antibiotics should be balanced against their access and affordability, and he recalled the importance of awareness and infection prevention. Generic medicines should continue to be recognized as part of the solution, and application of the flexibilities under the TRIPS agreement should be reaffirmed as a legitimate resort to encourage the affordability, accessibility and early commercialization of relevant medicines. Proposals to include monitoring of antimicrobial resistance as an International Health Regulations (2005) obligation should be closely considered. He asked for the phrase “in the absence of risk analysis” to be added to the end of paragraph 20 after “crop protection” in order to fully reflect the text of the global action plan for antimicrobial resistance.

The representative of CANADA said that given the multisectoral action required to combat the complex issue of antimicrobial resistance, her Federal Government was working with provincial and territorial governments, stakeholders and experts to develop a national action plan that considered the country’s specific needs. The report in document A69/24 had erroneously referred to Canada as having completed a national action plan; that needed clarification. She asked Member States to consider flexible, feasible and appropriate options for establishing a global development and stewardship framework, taking into account the different circumstances and needs of different countries. The development of the framework should be phased to ensure that its most critical elements received the most efficient consideration, even if that limited the initial scope. She stressed the need for a shared definition of “appropriate use” and for the issue of access to be included in all discussions on the framework.

(For continuation of the discussion, see the summary record of the seventh meeting, section 3.)

The meeting rose at 21:35.

SEVENTH MEETING

Thursday, 26 May 2016, at 09:10

Chairman: Mr M. BOWLES (Australia)

later: Ms T. KOIVISTO (Finland)

later: Mr M. BOWLES (Australia)

1. PREPAREDNESS, SURVEILLANCE AND RESPONSE: Item 14 of the agenda (continued)

Implementation of the International Health Regulations (2005): Item 14.1 of the agenda (continued from the fifth meeting)

- **Annual report on the implementation of the International Health Regulations (2005)** (document A69/20)

WHO response in severe, large-scale emergencies: Item 14.6 of the agenda (document A69/26) (continued from the fifth meeting)

2014 Ebola virus disease outbreak: Item 14.8 of the agenda (continued from the fifth meeting)

- **Options for strengthening information-sharing on diagnosis, preventive and therapeutic products and for enhancing WHO's capacity to facilitate access to these products, including the establishment of a global database, starting with haemorrhagic fevers** (document A69/29)

The representative of VIET NAM said that Member States should step up financial and human resources for the Global Outbreak Alert and Response Network in order to ensure support for Member States in crisis situations. Viet Nam had limited experience in responding to large-scale emergencies and needed support to improve its own capacities and participate in the Network.

The representative of the UNITED STATES OF AMERICA, referring to agenda item 14.6, said that the Secretariat should ensure that activities under the new Health Emergencies Programme took due account of the needs of especially vulnerable populations, including women, children, the elderly and persons with disabilities.

With regard to agenda item 14.8, crucial elements to prepare for outbreaks and reduce their impact were research and development and ensuring that all stakeholders had access to critical information. If WHO's Global Observatory on Health Research and Development was to be a reliable tool for inventorying research efforts and fostering innovation, it must be sufficiently resourced. Data collection should facilitate research agenda-setting by WHO's partners, rather than increase the Organization's own involvement in research and development. He urged the Secretariat to pilot a global database without delay, focusing first on products to prevent, diagnose and treat haemorrhagic fevers. It was to be hoped that the work envisaged to create a blueprint for research and development preparedness would improve coordination of global efforts and enhance research capacity, especially in vulnerable countries. Reports on progress made under the five workstreams should be shared with Member States at each stage of the blueprint's development.

The representative of the REPUBLIC OF KOREA said that the Global Observatory on Health Research and Development would provide a suitable option for hosting the global database and sharing information on diagnostic, preventive and therapeutic products. Proactive research on epidemic-prone diseases in developing countries was needed. Research and development cooperation should be strengthened at both national and international levels. Ensuring the availability of financing was also crucial. Active cooperation among all Member States would be needed to cope with the next global public health crisis.

The representative of BANGLADESH said that the establishment of a global database would expand and strengthen information-sharing. There were large gaps in knowledge and research on severe emerging infectious diseases. A multisectoral approach, better coordination and clear communication would be crucial in tackling future emergencies. Activities should be prioritized in order to make the best use of available resources.

The representative of CHINA said that Chinese medical personnel had assisted in response efforts following the earthquake in Nepal and the Ebola virus disease outbreak in Africa, and Chinese public health experts were currently supporting yellow fever prevention and control activities in Angola. China had an effective system for public health emergency information-sharing and capacity for the manufacture of diagnostic, preventive and therapeutic products that it was ready to share with international partners for use in responding to emerging disease challenges.

The representative of NORWAY, welcoming the research and development blueprint described in document A69/29, said that Norway was part of a coalition aiming to develop an international financing mechanism to support accelerated efforts to develop new vaccines and diagnostic tools for pathogens for which no commercially-driven research and development was being conducted. Such a mechanism should build on WHO's normative guidance, and the research and development blueprint should involve all relevant stakeholders, including vaccine producers. The aim was to ensure basic manufacturing capacity to facilitate rapid scale-up in the event of an outbreak, together with capacity for research and development in response to the emergence of new or unknown pathogens. Research and development efforts should complement other national and international outbreak prevention efforts.

The representative of TURKEY said that, although implementation of the International Health Regulations (2005) had unquestionably advanced global health security, timely detection and intervention in health emergencies remained a challenge. WHO should coordinate international efforts to improve global health security and response to health emergencies and humanitarian crises. Health system preparedness was crucial in dealing with humanitarian tragedies such as the current crisis in the Syrian Arab Republic. The Regulations were the most effective tool for ensuring preparedness. He supported their new monitoring and evaluation framework. Care should be taken to ensure that application of the Regulations did not unnecessarily interfere with travel or trade. He wished to express deep concern about the attacks on health-care facilities and staff in the Syrian Arab Republic.

The representative of JAPAN said that, when clinical trials were conducted under time pressure in emergency situations, ethical considerations must be borne in mind and transparency was crucial. The Pandemic Influenza Preparedness Framework was a model for ethical sharing of biological specimens. A balance must be struck between public health benefits under the International Health Regulations (2005) and the spirit of the Nagoya Protocol on Access to Genetic Resources and the Fair and Equitable Sharing of Benefits Arising from their Utilization to the Convention on Biological Diversity. Technology-sharing platforms should cover both vaccines and therapeutic products and have clear selection criteria for target diseases. The Secretariat should continue to ensure that Member States were involved in the development of a research and development framework.

The representative of the RUSSIAN FEDERATION, referring to agenda item 14.6, said that the Secretariat and Member States should step up efforts to identify resources at the national level that could, after certification by WHO, be deployed as part of WHO-led emergency response activities. To that end, the Secretariat should increase its outreach to Member States.

Turning to agenda item 14.8, he suggested that greater use should be made of WHO collaborating centres to develop diagnostic, preventive and therapeutic products for diseases with the potential to cause public health emergencies.

The representative of the BAHAMAS, commending the Secretariat's efforts to enhance information sharing, said that the countries of the Caribbean Community required support in order to establish research oversight frameworks and contribute to the global body of research. He requested the Director-General to share funding models and mobilization mechanisms widely and provide allocations specifically for Caribbean Community nations. Guidelines were needed on data protection, privacy and security measures for information-sharing through the Global Observatory. He appreciated the value of intersectoral approaches and engagement with the private sector, but warned that diligence must be exercised to avoid conflicts of interest.

The representative of BRAZIL said that the International Health Regulations (2005) had proved an important tool for transparency and rapid sharing of information in the current Zika virus outbreak in Brazil. Strict compliance with the Regulations was essential, including avoidance of restrictive measures not recommended by WHO that might negatively affect international travel and trade. His Government had set up a special task force to combat Zika virus infection, its associated consequences and its mosquito vector and was treating the situation as both a national and a global priority.

In order to strengthen WHO's capacity to facilitate access to diagnostic, preventive and therapeutic products, a framework for accelerated response should be developed and investment in research and development for vaccines and treatment should be increased. Related initiatives, such as the Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property and the work of the Consultative Expert Working Group on Research and Development, should be coordinated across the Organization. WHO had an important role to play in setting priorities for research and development for diseases that affected developing countries disproportionately. The Consultative Expert Working Group and the Organization as a whole should examine and act on the recommendations to be issued by the United Nations Secretary-General's High-Level Panel on Access to Medicines.

The observer of CHINESE TAIPEI said that Chinese Taipei had worked hard to improve its preparedness and large-scale emergency response capacity in the aftermath of the 1999 Jiji earthquake. It had received much international support and had reciprocated by offering support to countries hit by major earthquakes and other health emergencies. Chinese Taipei intended to set up a rapid response medical team to contribute to WHO's global emergency response work.

The representative of the GLOBAL HEALTH COUNCIL, speaking at the invitation of the CHAIRMAN, said that widespread assaults, abductions and killings of health workers and attacks on health-care facilities around the world were a matter of grave concern. He welcomed WHO's work to raise awareness and report such incidents. He encouraged Member States to ensure that the Secretariat had authority and resources required to enable it to perform its functions properly in large-scale emergencies.

The representative of the INTERNATIONAL ALLIANCE OF PATIENTS' ORGANIZATIONS, speaking at the invitation of the CHAIRMAN, said that refugees and internally displaced persons with chronic illnesses in regions affected by severe large-scale emergencies were often unable to obtain life-saving health care. She urged Member States to prioritize the health needs

of such persons. Her organization supported the establishment of regional emergency solidarity funds to ensure funding for emergency response in high-risk regions.

The representative of the INTERNATIONAL PHARMACEUTICAL FEDERATION, speaking at the invitation of the CHAIRMAN, said that pharmacists could play a valuable role in responding to large-scale emergencies, for instance by ensuring timely access to medicines. Noting that her organization planned to release guidelines to enhance the contribution of pharmacists in the implementation of disaster relief programmes, she called on governments to develop health-care policies on disaster management and emergency preparedness that included pharmacy professionals.

The representative of THE WORLD MEDICAL ASSOCIATION, INC., speaking at the invitation of the CHAIRMAN, welcomed WHO's collection of data on attacks on health-care workers and facilities in emergency settings. He called on governments to increase public communication about basic infection control, include disaster medicine in medical training and develop and test plans for the management of clinical care in disaster situations. He encouraged WHO to facilitate research on international interventions to inform plans for future health emergencies.

The representative of the INTERNATIONAL FEDERATION OF MEDICAL STUDENTS' ASSOCIATIONS, speaking at the invitation of the CHAIRMAN, said that the long-term solution for responding to severe large-scale emergencies was for countries to have the capacity to cope with hazards, mitigate their effects and manage their own disaster response. The international community should support affected countries' medium- and long-term rehabilitation, reconstruction and risk reduction efforts. Member States should strengthen their health systems in order to maintain health care in disaster situations. Urgent action was needed to address lack of respect for international humanitarian law and medical ethics in emergency situations. Enhanced training on humanitarian law should be provided to health workers.

The representative of MEDICUS MUNDI INTERNATIONAL – INTERNATIONAL ORGANISATION FOR COOPERATION IN HEALTH CARE, speaking at the invitation of the CHAIRMAN, said that the research and development blueprint and recent commitments on data sharing from stakeholders, funders and publishers did not go far enough with regard to collaboration. He encouraged Member States to consider research and development in the light of the follow-up to the recommendations of the Consultative Expert Working Group on Research and Development: Financing and Coordination, particularly with regard to de-linking of research and development costs from market price, and incorporate those principles to move towards a health-driven research and development environment. Open collaborative approaches should become the default for health research and for building an alternative biomedical research and development system.

The representative of WATERAID, speaking at the invitation of the CHAIRMAN, noted that there was little evidence of efforts to prevent a recurrence of the Ebola virus disease outbreak and said that the rhetoric on strengthening health systems should be matched by action. Affected countries should develop a funded strategy for strengthening health systems that provided for mutual support and collaboration. A plan that included equitable and sustainable access to safe water and sanitation would be critical to saving lives and reducing costs. Support for health systems strengthening must include the transfer of knowledge and skills for planning, monitoring and accountability. Although there was a need for political will, health systems strengthening must not be politicized.

The representative of the GAVI ALLIANCE, speaking at the invitation of the CHAIRMAN, said that rapid vaccine development during the Ebola virus disease outbreak had demonstrated that the public and private sectors could work together effectively. Nonetheless, significant work remained before vaccines could be used to protect populations from Ebola virus disease. WHO's leadership was needed in three areas: facilitating the use of investigational vaccines to tackle flare-ups by

evaluating dossiers submitted under the WHO Emergency Use Assessment and Listing mechanism and working with countries to streamline regulatory pathways for licensing and ensure countries' readiness to use vaccines; developing a target product profile for second-generation Ebola vaccines to guide development, ensure vaccines could address long-term needs and clarify essential vaccine attributes; and planning for the prophylactic use of Ebola vaccines, including by clarifying pathways for normative guidance.

The EXECUTIVE DIRECTOR ad interim (Outbreaks and Health Emergencies) said that it was clear from speakers' comments that the diversity of crises called for an all-hazards approach to disaster preparedness and response. Various speakers had highlighted the need for WHO to strengthen alliances with a broad range of technical, scientific and operational partners. Strengthening the global health emergency workforce, and the technical guidance that underpinned it, was a major priority in the WHO reform agenda. There were currently more people affected by protracted crises than ever, and surveys conducted over the previous two years had revealed that their greatest need was health care. Protracted crises were therefore also a priority, which would be addressed by strengthening health cluster presence in 2016 and 2017 and ensuring that evidence-based planning in protracted crisis settings was part of the Secretariat's work under the proposed programme budget 2018–2019. The work with regard to protracted crises was linked to the Secretariat's work in other areas, including the achievement of the Sustainable Development Goals. The Ebola virus disease outbreak had not yet ended, although about 30 days had passed since the last flare-up. The Secretariat was working both to address acute crises and to support long-term recovery.

Escalating attacks on health workers, services and transport in recent years were one of the most difficult challenges that the Organization faced in addressing large-scale emergencies. The Secretariat had released its first report on attacks on health care¹ as part of a broader effort to tackle the issue. The attacks were not isolated incidents and most were intentional. Their impact on the daily work of the Secretariat was huge, and Member States' assistance was needed in that area.

The ASSISTANT DIRECTOR-GENERAL (Health Systems and Innovation) said that the Secretariat was committed to scaling up the breadth of information available from the Global Observatory on Health Research and Development, pending receipt of adequate financial resources. The Secretariat had produced a document describing the way forward on the research and development blueprint,² which also outlined the early deliverables for the blueprint. In accordance with its research-related mandate under WHO's Constitution, the Secretariat had assumed responsibility for implementing clinical trials – including those on vaccines for Ebola virus disease – and was supporting the Government of Guinea in protecting its population against flare-ups of Ebola virus disease through vaccination. The Secretariat was grateful to the Member States and organizations that had provided financial support for its work on the blueprint, the Global Observatory and Ebola virus research and development.

The Committee noted the reports contained in documents A69/20, A69/26 and A69/29.

2. SECOND REPORT OF COMMITTEE A (document A69/70)

The RAPPORTEUR read out the draft second report of Committee A.

¹ Attacks on health care: prevent, protect, provide. Geneva: World Health Organization; 2016.

² An R&D Blueprint for Action to Prevent Epidemics: Plan of Action, May 2016. Geneva: World Health Organization; 2016.

The report was adopted.¹

Ms Koivisto took the Chair.

3. PREPAREDNESS, SURVEILLANCE AND RESPONSE: Item 14 of the agenda (resumed)

Global action plan on antimicrobial resistance: Item 14.4 of the agenda (documents A69/24 and A69/24 Add.1) (continued from the sixth meeting)

The representative of CHINA, noting the usefulness of the guidance manual for developing national action plans on antimicrobial resistance, said that the implementation of a global development and stewardship framework to support the development, control, distribution and appropriate use of new antimicrobial medicines, diagnostic tools, vaccines and other interventions should take into account socioeconomic differences between countries and regions. He welcomed the holding of the United Nations General Assembly High-level Meeting on antimicrobial resistance in September 2016; its programme, including side events, should be determined as soon as possible to allow early consultations on the participation of Heads of State and Government.

The representative of the REPUBLIC OF KOREA, welcoming the prompt action taken to implement the global action plan on antimicrobial resistance, said that the international community must work together, as the effects of antimicrobial resistance went beyond health: they would have an impact on socioeconomic development and progress towards attainment of the Sustainable Development Goals. The current discussion and the High-level Meeting on antimicrobial resistance would raise the political prominence of the matter. Her Government was currently preparing a national plan for preventing antimicrobial resistance and stood ready to work actively to achieve the goals of the global action plan.

The representative of the UNITED STATES OF AMERICA said that innovative arrangements for the development and implementation of the global development and stewardship framework should be explored. Involvement of the private sector would be essential. A whole-of-society approach involving the health and agriculture sectors, industry and research and development mechanisms was also needed. It made sense to start by limiting the scope of the framework to medically important antibiotics, with the selection to be guided by the WHO Model Lists of Essential Medicines and OIE's List of Antimicrobial Agents of Veterinary Importance. The framework should guide the proper manufacture, distribution and use of antibiotics in human and animal medicine and in agriculture. His Government would not advise reserving certain antibiotics exclusively for human use on the basis of a strictly precautionary approach; decisions to limit their use should be based on risk assessments. The outcomes of the work of the United Nations Secretary-General's High-Level Panel on Access to Medicines, whose report had not been released, should not be taken into account in developing the framework until the Health Assembly had had the opportunity to consider them.

The representative of the RUSSIAN FEDERATION said that tackling the problem of antimicrobial resistance required an integrated approach that included all sectors in which antimicrobial medicines were used. She supported a unified approach to stewardship of all classes of antimicrobial medicines. It was important to consider reserving some new and existing antimicrobial medicines for the treatment of complex cases, such as those involving comorbidity. The same approach should be applied to the use of antimicrobials in veterinary medicine and agriculture, and an

¹ See page 381.

effort should be made to reduce the maximum permitted level of antibiotics in food products of animal origin. Her Government welcomed the convening of the High-level Meeting on antimicrobial resistance and stood ready to participate in preparations for the event, including the drafting of a resolution or political declaration.

The representative of MALTA said that additional resources were needed to address antimicrobial resistance, as was a “One Health” approach. There was also an urgent need for harmonized surveillance systems to monitor antimicrobial resistance and awareness-raising of the issue through public communication and education. Her Government was developing a national strategy to reduce antimicrobial resistance. Its biggest challenge was to reduce the incorrect use of antibiotics in the community, but it had made significant headway in that regard.

The representative of MEXICO said that concerted action by all Member States was required to achieve the objectives of the global action plan, as was the involvement of all concerned sectors. His Government was working to reduce self-medication and promote rational use of antibiotics. It was an honour for Mexico to have been chosen to oversee the preparations for the High-level Meeting on antimicrobial resistance.

The representative of NEW ZEALAND said that WHO’s leadership on the issue of antimicrobial resistance was essential and encouraged the Director-General’s involvement in preparations for the High-level Meeting. She requested the Director-General to pursue work on the options for establishing a global development and stewardship framework with the participation of all relevant stakeholders. The framework should take the outcome of the High-level Meeting into consideration. A report on progress in developing the framework should be submitted to the Seventieth World Health Assembly.

The representative of EGYPT highlighted the importance of ensuring equal access to antimicrobials for developing countries. The WHO Model Lists of Essential Medicines should continue to be regularly updated. Support should be provided to developing countries for the improvement of microbiology laboratories and diagnostic methods for microbial testing and for the effective use of antibiograms in hospitals. The global action plan did not adequately cover the issue of regulation of over-the-counter antimicrobial products, and she therefore encouraged the Secretariat to formulate guidelines on their manufacture and distribution, whose use should be limited to specific groups, such as immunocompromised individuals. It should also develop effective risk communication messages for diverse populations.

The representative of MALDIVES said that her Government was developing a national action plan on antimicrobial resistance and carrying out awareness-raising initiatives. Work remained to be done to strengthen surveillance and research in order to understand and reduce the rate of resistance in Maldives. The country faced a lack of expertise and financial resources and she appealed for support in that regard.

The representative of INDIA, noting that various regulatory and other measures had been taken to combat antimicrobial resistance in India, said that concrete action should be taken through the global development and stewardship framework to promote affordable access to antimicrobial medicines, in line with the recommendations of the Consultative Expert Working Group on Research and Development. He asked the Director-General to highlight during the High-level Meeting on antimicrobial resistance the need to recognize and address the subject as a global development issue, raise awareness of it, and integrate sustainable and equitable access to medicines into the global development and stewardship framework.

The representative of SWEDEN said that the High-level Meeting would be a unique opportunity to raise awareness of antimicrobial resistance at the highest political level and send a clear call for action. All relevant organizations and sectors should be involved, and antimicrobial resistance should be placed in the context of the 2030 Agenda for Sustainable Development. He encouraged the Director-General to continue working with the United Nations Secretary-General to ensure a strong outcome to the High-level Meeting. The global development and stewardship framework required further exploration, and he looked forward to the progress report to be submitted to the Seventieth World Health Assembly.

The representative of ITALY said that over-prescription of antimicrobials, self-medication and Internet sales of antibiotics required regulation and global action. Point-of-care diagnostic tools would provide needed support to prescribers at the primary health care level. Pharmaceutical companies and regulatory authorities should be involved in WHO's discussions on antimicrobial resistance, as they could help to mitigate the problem and contribute to research on and development of new antibiotics. The G7 and G20 initiatives on antimicrobial resistance could strengthen WHO's leadership and help to build an economic case for solutions to antimicrobial resistance, which could in turn provide a basis for advocacy with governments and the public.

The representative of THAILAND, speaking on behalf of the Member States of the South-East Asia Region, said that it was to be hoped that the High-level Meeting would result in a global political commitment that would lead to sustainable multisectoral action and resources to tackle the challenge of antimicrobial resistance. Work on the global development and stewardship framework could be advanced by analysing the current situation in countries, including differences in their capacity for antibiotic research and development, stewardship and regulation, and narrowing down the options on that basis. A joint assessment mechanism and a global mechanism to ensure implementation of the global action plan should be part of the framework. Pharmaceutical companies should be involved in raising awareness of the prescription and use of antibiotics and in professional development activities for physicians, which could influence prescribing behaviour.

The representative of JAPAN said that regional collaboration, a multisectoral approach and strong political will were essential to counter antimicrobial resistance. A recent Asia-Pacific meeting of health ministers on antimicrobial resistance had contributed to enhanced regional collaboration and was expected to help to advance global efforts on the issue. The Director-General should continue to engage with the United Nations Secretary-General in the run-up to the High-level Meeting on antimicrobial resistance to ensure WHO's leadership in the area. The work on the global development and stewardship framework should take account of contextual differences between countries and should be designed with the participation of all stakeholders.

The representative of PAKISTAN said that high levels of antimicrobial resistance in Pakistan caused significant mortality and morbidity and limited treatment options. The situation in the animal sector was also alarming, as the use of broad-spectrum antibiotics was poorly regulated. His Government had launched institutional and legislative initiatives to combat antimicrobial resistance and intended to develop a national action plan in line with the global action plan.

The representative of COLOMBIA said that training in the appropriate use of antibiotics was the key to solving the problem of antimicrobial resistance. The pharmaceutical industry should be a strategic partner in encouraging the rational use of antibiotics and promoting research into new medicines. A system should be developed for the integrated surveillance of antimicrobial resistance in both humans and animals. Political will would be needed to ensure the adoption of regulations and control antibiotic use. In addition, legislation should be adopted to guarantee safe, effective and affordable medicines. She welcomed the emphasis in document A69/24 Add.1 on de-linking the cost of investment in pharmaceutical research and development from price and sales volume.

The representative of the ISLAMIC REPUBLIC OF IRAN suggested that a WHO consultative meeting should be held to determine the expected outcomes of the High-level Meeting. Those expectations could also be incorporated into national plans on antimicrobial resistance. One way of promoting surveillance of antimicrobial resistance might be to award research grants under the Global Antimicrobial Resistance Surveillance System. Data sharing among countries would facilitate antimicrobial stewardship; international awards for physicians who prescribed antibiotics properly might also help. The quality of antibiotics should be monitored at the international level in order to ensure that patients were not receiving substandard medicines.

The representative of INDONESIA, referring to the global development stewardship framework, said that it was important to formulate a set of priorities based on analysis of the real situation in countries, including differences in the capacity of their health systems. Indonesia had implemented an action plan in 2015 to strengthen multisectoral collaboration on antimicrobial resistance. She urged the Secretariat to support Member States in improving their laboratory systems and welcomed the convening of the High-level Meeting.

The representative of AUSTRALIA commended the Secretariat's efforts in the area of antimicrobial resistance and endorsed the statements made by the representatives of New Zealand, the Netherlands and the United Kingdom.

The representative of VIET NAM said that recent studies and surveillance had revealed high levels of antimicrobial resistance in his country. National policies and plans to combat resistance had been drawn up with a view to, inter alia, slowing the emergence of resistant bacteria, developing diagnostics tests to identify resistant strains, accelerating the developing of new antibiotics and raising public awareness of the problem. Viet Nam looked forward to the continued support of WHO.

The representative of ZIMBABWE, speaking on behalf of the Member States of the African Region, said that the threat of antimicrobial resistance should be viewed as a development issue, as it had already begun to reverse the gains made in public health. Priority should be given to supporting countries in adapting and implementing the global action plan. The Member States of the Region welcomed the convening of the United Nations High-level Meeting, which would provide an important platform for increasing awareness and political commitment. The global development and stewardship framework should be based on the principle of access to new and existing diagnostics and medicines. Disease burden should be taken into account in defining appropriate use in order to avoid further exacerbating the shortage of essential medicines, especially for vulnerable and poor populations. The proposal to prioritize antibiotics needed further deliberation and analysis of the possible implications. The Secretariat should prepare a document on the matter for consideration by the Executive Board at its 140th session, in January 2017.

The representative of SINGAPORE said that antimicrobial resistance was a global problem requiring a global solution, and WHO had a critical role to play in guiding the overall response. His Government had taken steps to enhance surveillance and deal with the rising prevalence of antimicrobial resistance and would continue to pursue regional and global collaboration to ensure a collective approach to combating antimicrobial resistance.

The representative of TUNISIA, welcoming the establishment of the infection prevention and control unit within the Secretariat, said that as part of its focus on preventing microbial transmission in surgical services, the unit should emphasize the importance of proper sterilization and disinfection of reusable medical instruments and encourage the use of disposable instruments. She supported the proposal to develop a prioritized list of antibiotics that would be subject to a global stewardship framework. Tunisia had established a national commission and surveillance system to combat antimicrobial resistance.

The representative of MALAYSIA called for a greater holistic and concerted effort to tackle the misuse of antimicrobials. She called on FAO and OIE to show equal commitment to that of WHO on the issue, in particular the continued and rampant use of antimicrobials as growth promoters in animals for food production. The pharmaceutical industry should be persuaded to engage in responsible marketing and balance commercial gain with the rational use of antimicrobials, and incentives for the development of new drugs to treat multidrug-resistant infections should be explored. WHO and its partners should take the lead in engaging with the pharmaceutical industry in promoting action on the issue. Member States should cooperate in ensuring stringent controls on the promotion, distribution and sale of antimicrobials, including via the Internet.

The representative of NORWAY, welcoming the emphasis on a “One Health” approach, said that she looked forward to learning more about the ongoing collaboration between WHO, FAO and OIE. Appropriate use of antimicrobials must be carefully balanced with access; too stringent controls might result in avoidable deaths, whereas too easy access might hasten the development of resistance. It was important for the United Nations High-level Meeting to conclude with clear goals and objectives for turning the tide of antimicrobial resistance. It should also serve to foster stronger collaboration among organizations in the United Nations system on the issue.

The representative of BARBADOS said that a national infection control committee had been set up in Barbados. One of its key roles was to provide education for physicians, farmers and the general public on infection control and proper use of antimicrobials. Barbados would require technical support to develop the economic case for sustainable investment in new medicines. It also needed support to develop a strong public health laboratory system and to review the prescribing practices of human and animal health professionals.

The representative of FIJI said that all Member States should develop national action plans on antimicrobial resistance by 2017. Her country had launched its plan in 2015. Antimicrobial resistance should be addressed not only as a technical issue, but also as a development issue.

The representative of BANGLADESH, noting that her country was pursuing an effective “One Health” approach to antimicrobial resistance, said that some options under consideration for the global development and stewardship framework might result in a weak approach. As the pharmaceutical industry might not voluntarily conduct research and development for the production of new antibiotics, it might be wise to consider developing a legally binding instrument along the lines of the WHO Framework Convention on Tobacco Control that could include provisions on conducting such research and development and on the manufacture of low-cost and effective antibiotics as a condition for national licensing of pharmaceuticals. In addition, WHO global guidelines and a standard operating protocol might be developed with a view to ensuring the production and marketing of a wide range of antibiotics.

The representative of COSTA RICA, noting that reporting of antimicrobial resistance had been mandatory in Costa Rica since 2012, affirmed that it was a serious global public health problem requiring an immediate national and global response, which should be delivered through national plans, with multisectoral involvement of the public and private sectors, ministries of agriculture and civil society. Sufficient human and financial resources must be allocated to implement the national plans.

The representative of SLOVAKIA said that screening should be conducted to detect multidrug-resistant bacteria in potentially colonized patients, contacts and healthy carriers. Strict epidemiological measures might be the only way to control some extremely antibiotic-resistant bacteria, and consideration should therefore be given, in the consultations on the global stewardship framework, to

developing internationally standardized epidemiological measures to control the spread of multidrug-resistant bacteria in hospitals and in communities.

The representative of ETHIOPIA, affirming his Government's commitment to implementing the global action plan, said that a multisectoral advisory board on the issue had been set up in Ethiopia and awareness-raising activities were being carried out. Countering the increasingly serious global threat of antimicrobial resistance needed global collaboration, including increased assistance to resource-limited countries, which were striving to contain the threat while trying to address numerous other domestic problems.

The representative of JORDAN stated that his country had developed a national action plan that, inter alia, sought to develop systems to detect antimicrobial-resistant bacteria and to promote the rational use of medicines in both humans and animals. The key to the success of the plan was raising awareness of the issue among health professionals and all persons involved in prescribing and using antibiotics. Antimicrobials should not be available without prescriptions.

The representative of SPAIN stressed that education was crucial and urged WHO to continue raising public awareness of the need for the rational use of medicines, emphasizing that they were not consumer goods but a therapeutic resource that must be preserved for future generations. Research on new antibiotics should be a priority. She supported the drawing up of a prioritized list of antibiotics that would be subject to a global stewardship framework. Her Government offered to provide technical support to countries that had yet to develop a national action plan.

The observer of CHINESE TAIPEI, expressing support for WHO's efforts to implement multi-pronged strategies to combat antimicrobial resistance and increase awareness of the issue, said that Chinese Taipei had introduced an antibiotic stewardship programme, which had helped to reduce multidrug-resistant infections and overuse of antibiotics. He encouraged WHO to engage all partners and stakeholders in promoting international action and global surveillance to combat antimicrobial resistance.

The representative of the GLOBAL HEALTH COUNCIL, speaking at the invitation of the CHAIRMAN, urged WHO to develop guidelines for health workers on the judicious use of antibiotics, which should include guidance on determining the likelihood of a bacterial infection and on weighing the potential benefits and harm of antibiotic use. Low- and middle-income countries would need new tools for that purpose, including alternative therapies and rapid point-of-care diagnostics. A coordinated and harmonized surveillance system was also needed, with internationally agreed standards for data collection and reporting. Associations of health professionals should be engaged in the fight against antimicrobial resistance.

The representative of the INTERNATIONAL COUNCIL OF NURSES, speaking at the invitation of the CHAIRMAN, said that health workers, particularly nurses, had a vital role to play in combating antimicrobial resistance, and the Council appreciated the involvement of nurses in the process of developing the global action plan. Nurses played a key role in all aspects of patient care, including education, and could thus make a valuable contribution to the success of global efforts to combat antimicrobial resistance. The Council therefore strongly encouraged the Secretariat and governments to involve nurses in the planning, development and implementation of relevant policies and strategies.

The representative of the INTERNATIONAL PHARMACEUTICAL FEDERATION, speaking at the invitation of the CHAIRMAN, said that her organization was keen to collaborate with WHO in implementing the global action plan. It had published a report in 2015 entitled "Fighting antimicrobial resistance: the contribution of pharmacists", which highlighted best practices worldwide and

underscored the role of professional organizations of pharmacists in implementing national antimicrobial resistance policies. The evidence contained in the report might prove useful to Member States in preparing their national action plans.

The representative of the WORLD MEDICAL ASSOCIATION INC., speaking at the invitation of the CHAIRMAN, highlighted the crucial role of physicians in the fight against antimicrobial resistance and the risks associated with distribution of antibiotics by non-qualified persons or without a prescription. He emphasized the importance of including veterinarians and the agricultural sector in actions taken to combat the problem, and urged WHO to involve FAO and OIE in awareness-raising. The role of international travel, goods transportation and trade agreements in the development of antimicrobial resistance should be examined. Education on appropriate prescribing practices should be included in medical and veterinary school curricula and in continuing education for physicians and veterinarians. He urged Member States to allocate the necessary funds to implement the global action plan.

The representative of the INTERNATIONAL FEDERATION OF MEDICAL STUDENTS' ASSOCIATIONS, speaking at the invitation of the CHAIRMAN, urged Member States to prioritize the creation of robust national actions plans and involve all relevant actors in their implementation. It was important to strengthen surveillance systems to monitor resistance patterns, as there were serious gaps in both regional and international surveillance. A root cause of antimicrobial resistance was the lack of innovation in the development of new antibiotics and infectious disease management technology. Current research and development models had proved insufficient and alternatives were needed, as recommended by the WHO Consultative Expert Working Group.

The representative of MEDICUS MUNDI INTERNATIONAL – INTERNATIONAL ORGANIZATION FOR COOPERATION IN HEALTH CARE, speaking at the invitation of the CHAIRMAN, said that public leadership was needed to promote new needs-driven research and development models that would support rational use of and equitable access to antibiotics. Publicly-funded research and development should be guided by the principles of affordability, effectiveness, efficiency, equity and the de-linkage of research costs from market price. As resistance to last-line antimicrobials had become evident, decisive action was imperative. He urged WHO to take a leadership role in preparations for the United Nations high-level meeting.

The representative of WATERAID, speaking at the invitation of the CHAIRMAN, said that the core components of infection prevention and control should be included in national action plans, which should incorporate targets and routine monitoring for water, sanitation, hygiene and waste management in health care facilities. She noted that WHO, UNICEF and other partners were collaborating in promoting infection prevention and control under a global action plan for water, sanitation and hygiene in health-care facilities.

The representative of STICHTING HEALTH ACTION INTERNATIONAL, speaking at the invitation of the CHAIRMAN, said that any measures taken to ensure appropriate use of antibiotics should be based on scientific evidence. The stewardship framework should reflect the principles of equity, justice and sustainability and take account of the varying ecological and epidemiological contexts in which antibiotics were used. Understanding the interplay of logistic, environmental, financial and social drivers of antibiotic use was the key to developing effective strategies for combating resistance. Funds should be mobilized to close information gaps. Countries should define clear indicators to monitor antibiotic use and access. The development of easy-to-use and affordable point-of-care diagnostics for low-resource settings should be prioritized. WHO should lead the way in building partnerships and coalitions to tackle antimicrobial resistance.

The representative of OXFAM, speaking at the invitation of the CHAIRMAN, said that progress in addressing antimicrobial resistance would require global collaboration and coordination on relevant current initiatives, in particular the United Nation Secretary-General's High-Level Panel on Access to Medicines and its work to redress the incoherence between human rights, trade and intellectual property policies in the context of research and development and access to medicines. She urged Member States to prioritize the financing of research and development for health technologies to combat antimicrobial resistance and ensure adequate funding to support WHO's leadership and coordination role. She also urged support for the negotiation of a global convention on research and development to ensure access to affordable health technologies for all.

The representative of MÉDECINS SANS FRONTIÈRES INTERNATIONAL, speaking at the invitation of the CHAIRMAN, said that the multiple initiatives intended to make antimicrobial resistance a political priority must be coordinated so that they did not result in parallel or conflicting processes. She urged the Secretariat and Member States to ensure that the needs of developing countries and vulnerable populations were considered when priorities were set, products designed and stewardship strategies developed. The High-level Meeting would provide an opportunity to initiate negotiations for global frameworks, including one for development and stewardship. In preparation for that meeting, Member States should implement national action plans and collect surveillance data on the causes, prevalence and impacts of antimicrobial resistance and commit to the development of target product profiles to guide research and development. Any global agreements on the issue should be aligned with the recommendations of the Consultative Expert Working Group and the High-level Panel on Access to Medicines, especially with regard to de-linkage.

The representative of the INTERNATIONAL UNION AGAINST TUBERCULOSIS AND LUNG DISEASE, speaking at the invitation of the CHAIRMAN, said that action needed to be taken to tackle multidrug-resistant tuberculosis and extensively drug-resistant tuberculosis, which had now been reported in at least 100 countries. Governments should adopt the recent WHO recommendation for a shorter, nine-month treatment regimen for multidrug-resistant tuberculosis and incorporate it into their national clinical guidelines. Scaling up the availability of high-quality tuberculosis treatment services was also essential to preventing new drug resistance.

The representative of the INTERNATIONAL FEDERATION OF PHARMACEUTICAL MANUFACTURERS AND ASSOCIATIONS, speaking at the invitation of the CHAIRMAN, said that the pharmaceutical industry was at the forefront of action to address antibiotic resistance. In January 2016, more than 100 pharmaceutical, biotechnology and diagnostics companies had signed a declaration committing themselves to reduce the emergence of drug resistance, increase investment in research and development to meet global public health needs, and improve access to high-quality antibiotics and vaccines. Antibiotic stewardship must be a part of any solution to curb antimicrobial resistance. Access to antibiotics was only part of the solution, however. Comprehensive efforts to improve sanitation, hygiene, vaccination rates, infection control and education were also needed.

The SPECIAL REPRESENTATIVE OF THE DIRECTOR-GENERAL (Antimicrobial Resistance) said that the main challenge of antimicrobial resistance was the sheer scope and complexity of the issue. It had direct impacts not only on humans but on agriculture and food supply. Antimicrobial resistance also raised concerns in relation to development, access and the achievement of the Sustainable Development Goals. It was clear, therefore, that a multisectoral response was needed. However, health must remain at the centre of that response. At the same time, different stakeholders and partners, including from the private sector and civil society, must be engaged in the effort to combat antimicrobial resistance. A "One Health" approach required WHO to work particularly closely with FAO and OIE. It was also necessary to coordinate with other initiatives. As several speakers had noted, varying contexts and conditions in countries had to be taken into account.

The global action plan addressed many of the issues raised in relation to surveillance, guidance, knowledge gaps and other matters. Work in 2016 should focus on the development and implementation of national action plans and continued exploration of options for the global development and stewardship framework. The Secretariat was grateful for the input received thus far and, as requested, would submit a progress report on the work on the global development and stewardship framework to the Executive Board at its 140th session in January 2017. A third important area of focus in 2016 was mobilization of high-level political engagement. The United Nations General Assembly High-level Meeting on antimicrobial resistance would be critical in that regard. He announced that the suggested corrections to document A69/24 Add.1 had already been made electronically and acknowledged that the outcomes of the work of the Secretary-General's High-Level Panel on Access to Medicines were not yet available as that work had not yet concluded.

The Committee noted the report.

Mr Bowles resumed the Chair.

Poliomyelitis: Item 14.5 of the agenda (document A69/25)

The representative of PAKISTAN said that the total number of cases of poliomyelitis in Pakistan had fallen from 24 in 13 districts in 2015 to 11 in 8 districts in 2016. Eradication remained a national priority, and eradication efforts were overseen directly by the Prime Minister. Several vaccination rounds had been carried out at the national and subnational levels; all children were routinely being given one dose of inactivated poliomyelitis vaccine at 14 weeks of age, together with the pentavalent vaccine. Specialized teams performed forensic analysis, data review and field visits to identify areas of sub-optimal vaccination coverage. Access to previously inaccessible areas of the country had improved dramatically. Joint action plans were being carried out in collaboration with the Government of Afghanistan to halt transmission in the Khyber-Peshawar-Nangarhar and Quetta-Greater Kandahar corridors. His Government counted on the continued support of the international community to bolster national efforts.

The meeting rose at 12:30.

EIGHTH MEETING

Thursday, 26 May 2016, at 14:35

Chairman: Mr M. BOWLES (Australia)

1. PREPAREDNESS, SURVEILLANCE AND RESPONSE: Item 14 of the agenda (continued)

Poliomyelitis: Item 14.5 of the agenda (document A69/25) (continued)

The representative of SWITZERLAND, speaking on behalf of the Member States of the European Region, called for the full implementation of the recommendations made by the Emergency Committee under the International Health Regulations (2005) regarding the international spread of poliovirus at its ninth meeting. He welcomed the progress made in Pakistan and Afghanistan on interrupting wild poliomyelitis transmission, with particular regard to cross-border collaboration, which was a priority for 2016. He supported the strong focus under the Polio Eradication and Endgame Strategic Plan 2013–2018 on bringing an end to cases of circulating vaccine-derived poliovirus and on strengthening outbreak response capacity, and requested an update from the Secretariat on the progress of the global switch from trivalent oral poliovirus vaccine to bivalent oral poliovirus vaccine, which had taken place in April 2016. Member States affected by the supply shortage of inactivated poliovirus vaccine should be provided with clear guidance on strategies to mitigate risk. It was also important to ensure a legacy for the investment that had been made towards poliomyelitis eradication: WHO should draw up possible strategies and solutions regarding the future of assets funded by the Global Polio Eradication Initiative, including non-polio eradication functions, and Member States should finalize national legacy plans. In relation to financing, WHO should distribute an updated and disaggregated budget for the period 2016–2019 for efforts towards poliomyelitis eradication; he encouraged donors and affected countries to continue to provide funding.

The representative of AFGHANISTAN said that polio eradication efforts in his country had intensified significantly. Emergency operation centres and provincial coordination units had been established in priority regions to manage poliomyelitis eradication efforts. Permanent transit teams had been deployed to inaccessible areas to increase immunization coverage and regular communication with Pakistan helped to reduce cross-border transmission. However, some challenges still remained, including insecurity and inaccessibility in affected areas. The global shortage of inactivated poliovirus vaccine should be addressed by WHO.

The representative of MONACO said that efforts must continue until all forms of poliomyelitis were eradicated. Although the switch to bivalent oral poliovirus vaccine had been a great success, WHO must ensure access to inactivated poliovirus vaccine and provide technical assistance when required. Legacy-planning strategies should include the transfer of knowledge, capabilities, assets and processes and involve all partners. She called on WHO to convene a high-level meeting on legacy planning in 2017.

The representative of CANADA commended the elimination of poliomyelitis in Nigeria, the switch from trivalent to bivalent oral poliovirus vaccine, and the commitment in Pakistan and Afghanistan to stop cross-border transmission. However, work must continue within the framework of the Polio Eradication Endgame Strategic Plan 2013–2018 to reach inaccessible areas and to enhance surveillance and technical support in countries at risk of vaccine-derived poliomyelitis and in countries

introducing the inactivated poliovirus vaccine. Discussions on legacy should involve major health stakeholders to ensure the effective transfer of assets and personnel.

The representative of TURKEY expressed appreciation for the achievements of Pakistan and Afghanistan and called on the Secretariat and all Member States to support the final efforts to eradicate poliomyelitis. The Secretariat should continue to foster the transfer of vaccine production technology and should increase efforts to advise vaccine producers and Member States in the face of the bivalent oral poliovirus vaccine shortage. His country had switched to bivalent oral poliovirus vaccine; it continued to offer comprehensive health services, including vaccination and surveillance activities, to high-risk populations, including migrants. A global response was needed to support those areas facing complex health emergencies.

The representative of the UNITED REPUBLIC OF TANZANIA said that his Government had taken measures to rectify low coverage with oral poliovirus vaccine, had switched from trivalent to bivalent oral poliovirus vaccine, and had allocated funding for disease surveillance and response. However, he expressed concern about the limited supply of inactivated poliovirus vaccine, and urged the Secretariat to facilitate increased production in line with the scheduled withdrawal of trivalent oral poliovirus vaccine. The Secretariat should also support countries experiencing outbreaks of circulating vaccine-derived poliovirus.

The representative of IRAQ said the switch to bivalent oral poliovirus vaccine had been completed in his country, and recognized that it was of utmost important to ensure the procurement and sustained supply of inactivated poliovirus vaccine and bivalent oral poliovirus vaccine. The Secretariat should facilitate access to monovalent oral poliovirus vaccine type 2 in case of an outbreak due to that strain. His Government requested support for immunization campaigns, capacity-building for staff engaged in epidemiological and laboratory surveillance of acute flaccid paralysis, and the introduction of environmental surveillance. Addressing outbreaks was a top priority for Afghanistan, the Islamic Republic of Iran, Iraq, Pakistan and the Regional Office for the Eastern Mediterranean.

The representative of TOGO, speaking on behalf of the Member States of the African Region, welcomed the considerable progress made, including the certification of Nigeria as being free of wild poliovirus, but expressed concern at the limited availability of inactivated poliovirus vaccine. He supported the strategies to completely interrupt transmission, such as the switch to bivalent oral poliovirus vaccine, the strengthening of routine surveillance and immunization, and legacy planning, all of which required financial support.

The representative of KENYA drew attention to measures taken by his Government including the introduction of the inactivated poliovirus vaccine into routine immunization schedules, the establishment of environmental surveillance, and the switch from trivalent to bivalent oral poliovirus vaccine. However, progress was being hindered by several challenges including insecurity, inaccessibility of vaccination services in some hard-to-reach areas and inadequate funding for acute flaccid paralysis surveillance.

The representative of MALTA acknowledged that it was important not to become complacent; her Government had ensured that polio eradication remained a priority in health care, both nationally and within the international community. Once the goal to eradicate polio had been achieved, immunization coverage and surveillance should continue, to ensure that global poliomyelitis-free status was maintained.

The representative of the PHILIPPINES said that all remaining type 2 vaccine-derived polioviruses and Sabin type 2 strains in her country had been destroyed, and the Government had

begun the switch to bivalent oral poliovirus vaccine. She encouraged Member States to further collaborate to achieve global eradication.

The representative of the REPUBLIC OF KOREA noted the achievements of Pakistan, Afghanistan and the international community, but said that the vaccine shortage still posed a major challenge to global eradication, exacerbating communication with the public. Although the switch from oral to injectable vaccines would be crucial, it could cause further vaccine shortages in countries already using inactivated poliovirus vaccines. She therefore encouraged the Secretariat to intervene on the matter and provide guidance in that regard.

The representative of JAPAN commended the historic progress made, particularly the removal of Nigeria from the list of poliomyelitis-endemic countries. It was vital to ensure that the legacy of poliomyelitis eradication assets benefited other health areas, including emergency responses to outbreaks of other infectious diseases. Cases of paralytic poliomyelitis caused by vaccine-derived poliovirus in some countries indicated that herd immunity was insufficient, indicating that immunization efforts must continue. She noted with concern the shortage of inactivated poliovirus vaccine, but informed the Committee that a Japanese pharmaceutical company had started production of inactivated poliovirus vaccine, in order to help to redress that shortage. Her Government was committed to the eradication of poliomyelitis and would continue offering financial and technical assistance in that regard.

The representative of GERMANY said that it was time to take the final step to eradicate poliomyelitis from the remaining two endemic countries, Afghanistan and Pakistan. In addition to the €100 million that his Government had already contributed towards the Polio Eradication and Endgame Strategic Plan 2013–2018, it would provide €2.5 million for eradication in Pakistan in 2016 and, subject to the availability of funds, planned hoped to contribute €10 million by 2018. The detection of circulating vaccine-derived type 1 polioviruses in Madagascar and Ukraine had underscored the urgent need for comprehensive inactivated poliovirus vaccine coverage. It was vital that enough vaccine was made available in line with planned introduction timescale. He called for a country-led approach to legacy planning, aligning that work with efforts to strengthen the core capacities under the International Health Regulations (2005).

The representative of the ISLAMIC REPUBLIC OF IRAN said that in order to eradicate polio Member States needed to prioritize the enhancement of inactivated poliovirus vaccine production and provide financial and technical support to vaccine manufacturers in developing countries so as to overcome the severe shortage following the switch to bivalent oral poliovirus vaccine. Global surveillance systems, including environmental surveillance, should be improved to confirm interruption in the circulation of wild poliovirus and vaccine-derived poliovirus type 2. Regional cooperation to monitor and report cross-border transmission was crucial, particularly as his country neighboured the two countries remaining endemic for polio.

The representative of the UNITED KINGDOM OF GREAT BRITAIN AND NORTHERN IRELAND welcomed the removal of Nigeria from the list of endemic countries, the unprecedented global switch from trivalent to bivalent oral poliovirus vaccine, and recent rapid responses to the environmental detection of poliovirus type 2. Global eradication would be a significant achievement in public health and would contribute to attainment of the Sustainability Development Goals. The Polio Eradication and Endgame Strategic Plan 2013–2018 needed to be fully financed and, to that end, the United Kingdom had committed £300 million for the period 2013–2019 and he urged other countries to commit further resources. The continued high-level commitment of the Governments of Afghanistan and Pakistan and the bravery of frontline health workers were commendable. It was crucial to overcome the shortage of inactivated poliovirus vaccine as soon as possible, and to consider the value of legacy planning for global health security, with particular regard to other infectious

diseases. He asked the Secretariat to provide Member States with more detail on the funding implications for WHO following the global eradication of poliomyelitis.

The representative of the UNITED STATES OF AMERICA said that, even with the great progress made in eradication efforts in Pakistan and Afghanistan, especially regarding cross-border transmission, concerns remained that wild poliovirus transmission may not be interrupted in 2016. The unprecedented global switch from trivalent to bivalent oral polio vaccine was a major positive step. Member States should maintain high-quality environmental and acute flaccid paralysis surveillance, to work towards closing any remaining immunity gaps and to maintain what had already been achieved. The continued shortage of inactivated poliovirus vaccine was particularly concerning, and he urged manufacturers to ensure a secure supply. The Secretariat should support efforts to destroy type 2 poliovirus materials and ensure legacy planning. Her Government had increased its financial support to the Global Polio Eradication Initiative and urged other Member States to help to meet the funding gap for implementing the Polio Eradication and Endgame Strategic Plan 2013–2018.

The representative of BHUTAN, speaking on behalf of the Member States of the South-East Asia Region, observed that the Region had remained free of wild poliovirus for more than five years. All 11 Member States had switched from trivalent to bivalent oral poliovirus vaccine and were introducing inactivated poliovirus vaccine into their routine immunization programmes. Recognizing the high cost and continued global shortfall of inactivated poliovirus vaccine, he said the new WHO guidance on using fractional doses of the vaccine was not enough to overcome that barrier as it would take too long to assess programmatic feasibility in some countries. WHO and relevant partners needed to focus on facilitating the timely, uninterrupted and affordable supply of vaccines to control potential outbreaks. Member States should maintain high vaccine coverage and robust surveillance systems and ensure that the investments made in poliomyelitis eradication would contribute to future health goals. He requested additional guidance on the containment of poliovirus for research purposes.

The representative of DENMARK said that the collaboration of all Member States was essential to successfully implement the Polio Eradication and Endgame Strategic Plan 2013–2018. However, as Denmark was a poliovirus vaccine-manufacturing country, her Government had concerns about the certification process for poliovirus facilities, which could be burdensome and cost-intensive, especially in countries with only one or few such facilities. WHO should play a more prominent role in the certification process and devise a more realistic time frame.

The representative of THAILAND said that the switch from trivalent to bivalent oral poliovirus vaccine had already been made in Thailand, but the country faced the challenges of the high cost and short supply of inactivated poliovirus vaccine, threatening to undermine the immunity of children who had previously been vaccinated. The vaccine shortage should have been anticipated well in advance. The Strategic Advisory Group of Experts on immunization had not properly consulted with stakeholders and her Government accordingly emphasized that an inclusive and participatory consultation process was crucial to achieving the Polio Eradication and Endgame Strategic Plan 2013–2018, especially when decision-making required political commitment and changes to national legislation and affected domestic budgets.

The representative of the RUSSIAN FEDERATION expressed satisfaction about the work being done to increase vaccine coverage in endemic countries, but concern that some countries continued to register outbreaks caused by circulating vaccine-derived polioviruses and that the response was sometimes slow. The relevant temporary recommendations of the IHR Emergency Committee regarding the international spread of poliovirus should continue to be applied. Implementation of the Polio Eradication and Endgame Strategic Plan 2013–2018 would minimize the risk of new international transmission of polioviruses and strengthen global surveillance. Trivalent

oral poliovirus vaccine was no longer used in the Russian Federation and measures had been taken regarding the containment of wild and vaccine-derived poliovirus in laboratories in the country.

The representative of ECUADOR said that the global switch from the trivalent to bivalent oral poliovirus vaccine in the given time frame was a milestone in progress towards global eradication. Despite the earthquake in his country in April 2016, the switch had been successfully completed and all trivalent oral poliovirus vaccines were recovered and destroyed. His Government would continue to ensure the necessary measures were taken to maintain vaccine coverage and develop an effective epidemiological surveillance system.

The representative of NIGERIA, recalling that his country had been removed from the list of endemic countries in September 2015, said that it had achieved the first two objectives under the Polio Eradication and Endgame Strategic Plan 2013–2018. Inactivated poliovirus vaccine had been introduced into the national routine immunization programme and Nigeria had been designated as a tier 1 country for the prioritization of introduction of that vaccine. The switch had been made from trivalent to bivalent oral poliovirus vaccine and all poliovirus type 2 material had been destroyed. Legacy planning was ongoing in the country. The Global Polio Eradication Initiative should continue to prioritize Nigeria in vaccine and resource allocation in order to achieve certification and to reduce the risk of outbreaks.

The representative of MEXICO said that, for as long as there continued to be a risk of circulation or importation of poliovirus, it was vital to maintain routine poliovirus vaccine coverage and monitoring of acute flaccid paralysis. The switch from trivalent to bivalent oral poliovirus vaccine and the introduction of inactivated poliovirus vaccine were essential steps towards the eradication of wild poliovirus globally, as was destruction of poliovirus type 2 materials.

The representative of TIMOR-LESTE said that in the past month the country had switched from using trivalent to bivalent oral poliovirus vaccine and had introduced inactivated poliovirus vaccine into its routine immunization programme. However, his Government had still to address the lack of human and financial resources and weaknesses in surveillance systems, identifying cases of acute flaccid paralysis and laboratory capacity to detect vaccine-derived polioviruses. He urged continued provision of support by WHO and its partners.

The representative of CHINA said that his country had successfully made the switch from trivalent to bivalent oral poliovirus vaccine and was undertaking the recovery and destruction of poliovirus type 2 materials. Inactivated poliovirus vaccine had also been integrated into the national immunization programme. Given the risk in developing countries of the importation or transmission of wild poliovirus, the Secretariat should continue to provide the necessary technical support to Member States to develop action plans, promote cross-border and regional cooperation, and accelerate the eradication process.

The representative of EGYPT, reaffirming her Government's commitment to the transition from trivalent to bivalent oral poliovirus vaccine and to the introduction of the inactivated poliovirus vaccine, said that the switch had not been possible because of the delay in delivery of inactivated poliovirus vaccine supplies; their receipt was scheduled for the third quarter of 2017. Consequently, an excess of trivalent oral poliovirus stocks remained; as they had not passed their expiry date, under Egyptian law they could not be discarded. Egypt was a low-risk country, having eliminated poliomyelitis, but two recent poliomyelitis-related epidemiological situations gave cause for concern. She requested clarification of WHO's recommendation with regard to the use of one single or two fractional doses of inactivated poliovirus vaccine, and the timing of administration. The delays in provision of the inactivated vaccine had not been expected from an organization such as WHO;

shortages should be overcome if countries were to complete the switch to bivalent oral poliovirus vaccine.

The representative of AUSTRALIA welcomed the removal of Nigeria from the list of poliomyelitis-endemic countries and the reduction in wild poliovirus cases in Pakistan. In Australia, inactivated poliovirus vaccine had been introduced into national immunization campaigns and a poliovirus-essential facility had been designated for which the relevant biosafety requirements would be met. Legacy planning was particularly important to ensure that investment in poliomyelitis eradication would be of sustained benefit to other health priorities.

The representative of INDONESIA said that, despite Indonesia's disassociation from paragraphs 2, 3(7) and 4(2) of resolution WHA68.3 (2015) on poliomyelitis, efforts had been made in the country to switch from trivalent to bivalent oral poliovirus vaccine. Nationwide immunization days had been held against poliomyelitis, and more than 23 million children had been vaccinated with trivalent oral poliovirus vaccine. Efforts would be made to introduce the inactivated poliovirus vaccine by July 2016. However, in line with the Polio Eradication and Endgame Strategic Plan 2013–2018, she called for synchronization of the withdrawal of trivalent oral polio vaccine, the introduction of inactivated poliovirus vaccine and immunization system strengthening in all countries. The global shortage of inactivated poliovirus vaccine was a concern and should be rectified, since it was jeopardizing efforts to meet the objectives of the Strategic Plan.

The representative of SOUTH AFRICA commended Nigeria's successful eradication of poliomyelitis. In South Africa, the switch from trivalent to bivalent oral poliovirus vaccine had been successful. She expressed her Government's gratitude to the Secretariat for its support during the planning and implementation of the switch.

The representative of the BAHAMAS said that inactivated poliovirus vaccine had been introduced successfully in the national immunization schedule in 2015 and a campaign had been launched to educate health-care workers about various components of the inactivated poliovirus vaccine, the withdrawal of type 2 oral poliovirus vaccines, and the global synchronized switch. The switch had been successfully made in his country, and all remaining stocks of trivalent oral poliovirus vaccines had been destroyed. He commended WHO's work to promote poliomyelitis eradication, but cautioned that sufficient supplies of inactivated and bivalent poliovirus vaccines must be available to meet demand. Member States must continue to be vigilant, as pockets of disease and lapses in vaccination activities left all countries at risk.

The representative of SOMALIA said that her country had been poliomyelitis-free for nearly two years owing to the high level of political commitment, strong support of partners including WHO, and a flexible, innovative and comprehensive approach to immunization campaigns. However, 17 districts in the south and centre of Somalia remained inaccessible for vaccine coverage and an estimated 397 000 children under 5 years of age were not vaccinated. Routine immunization coverage remained low, and shortages of inactivated poliovirus vaccine were a cause for concern. Partners and donors should continue to provide support until eradication had been achieved worldwide.

The representative of BAHRAIN said that his Government had made progress towards meeting the objectives of the Polio Eradication and Endgame Strategic Plan 2013–2018. Surveillance systems had been enhanced to ensure early detection of any possible cases. The switch to bivalent oral poliovirus vaccine had taken place and was being monitored in a series of site visits.

The representative of BARBADOS, recognizing the costs of vaccine-preventable diseases said that his Government continued to implement the Polio Eradication and Endgame Strategic Plan 2013–2018. The switch to bivalent poliovirus vaccine had been successfully achieved and inactivated

poliovirus vaccine was being included in the Government's Expanded Programme of Immunization. A monitoring and evaluation framework had been established and continued assistance and guidance from WHO would be welcome.

The representative of the DOMINICAN REPUBLIC said that, although no case of wild poliovirus had been registered in the Dominican Republic since 1985, one case of vaccine-associated paralytic poliomyelitis had been registered in 2001. Inactivated poliovirus vaccine had been introduced, and the switch from trivalent to bivalent oral poliovirus vaccine had been completed successfully in the context of Vaccination Week in the Americas. The immunization schedule was being met and a review committee had been established to evaluate the switch.

The representative of MOROCCO said that the national immunization plan assured coverage with three doses of oral poliovirus vaccine; the coverage rate was 97% of children. Efforts had been made to ensure the successful switch from trivalent to bivalent oral poliovirus vaccine and to introduce inactivated poliovirus vaccine. He expressed concern with regard to the global shortage of inactivated poliovirus vaccine. The Secretariat should take all the necessary measures to ensure that sufficient vaccine stocks were available to allow Member States to make the progress required of them.

The representative of JORDAN noted that vaccine coverage in his country was more than 95% for children, and the national laboratory dealing with poliomyelitis had received WHO certification. Technical assistance from the Secretariat had enabled the spread of the virus to be restricted despite the threat of reintroduction from neighbouring countries. The switch from trivalent to bivalent oral poliovirus vaccine had been successful. Despite the large intake of refugees, which placed a considerable burden on the health system, efforts were being made to ensure vaccination coverage for residents of Jordan and refugees alike, and to eradicate other communicable diseases. He requested technical assistance from the Secretariat for the acquisition of vaccine stocks to continue its vaccination campaigns.

The representative of GHANA welcomed global efforts to meet the four objectives of the Polio Eradication and Endgame Strategic Plan 2013–2018 and commended Nigeria's successful interruption of poliovirus transmission. The Ghanaian authorities had taken steps to destroy all materials suspected of containing wild poliovirus type 2 and had completed the switch from trivalent to the bivalent oral poliovirus vaccine. Efforts to introduce inactivated poliovirus vaccine had been stepped up. He noted with concern the drop in support for acute flaccid paralysis surveillance and said that urgent steps must be taken to find innovative ways to ensure sustainable funding in that regard.

The representative of JAMAICA said that the risk of reintroduction of poliomyelitis remained high, owing to large influxes of tourists and immunization coverage at less than 95%. Concerted efforts had resulted in improved immunization coverage and the establishment of a strong active surveillance system. The single-dose schedule of inactivated poliovirus vaccine had been implemented in September 2015, with a transition to a two-dose schedule in 2016. The switch from trivalent to bivalent oral poliovirus vaccine had been successful; a final report on the transition was being prepared. Containment activities had been conducted and progress was being made towards meeting all four objectives of the Polio Eradication and Endgame Strategic Plan 2013–2018.

The representative of TUNISIA expressed concern regarding the limited availability of inactivated poliovirus vaccine. In Tunisia, the health ministry had taken steps to strengthen the national immunization programme and the poliomyelitis eradication initiative, had implemented a passive and active surveillance system for acute flaccid paralysis, had introduced a single dose of inactivated poliovirus vaccine, and had successfully switched from trivalent to bivalent oral poliovirus vaccine. He advised the Secretariat of the difficulties faced by countries with developing and transitional economies with regard to vaccine procurement and meeting vaccine schedules.

The representative of the DEMOCRATIC REPUBLIC OF THE CONGO said that his country had been declared polio-free in November 2015. The switch from trivalent to bivalent oral poliovirus vaccine had been a success. Insufficient global production of the inactivated poliovirus vaccine and low oral poliovirus vaccine coverage in insecure regions were causes for concern. He encouraged the Secretariat to extend its efforts to ensure a sufficient supply of the inactivated poliovirus vaccine, and provide technical and financial support so that poliomyelitis could be eradicated in 2018 as planned.

The representative of QATAR acknowledged the poliomyelitis eradication efforts in Afghanistan and Pakistan. His Government was cooperating with other countries to mitigate the risk of wild poliovirus resurgence, and had put in place a preparedness and response plan for imported cases. He urged the Secretariat to work on the problem of vaccine supply in general and the inactivated poliovirus vaccine in particular.

The representative of BOTSWANA said that her Government had introduced the inactivated poliovirus vaccine and had switched from trivalent to bivalent oral poliovirus vaccine, but the destruction of the recalled trivalent oral poliovirus vaccine was ongoing. The possible shortage of inactivated poliovirus vaccines was a cause for concern, particularly in countries that had already switched to bivalent oral poliovirus vaccine. She asked the Secretariat to monitor the supply situation closely, as it could affect the success of national immunization programmes.

The representative of INDIA outlined actions taken by his Government to ensure that India would remain poliomyelitis-free, including annual vaccination rounds and vaccination posts at rail and road routes along the country's borders. The switch from trivalent to bivalent oral poliovirus vaccine had been a success and surveillance of acute flaccid paralysis had been expanded. Introduction of inactivated poliovirus vaccine had begun before the switch, but had been phased because of a lack of supply. A fractional dose schedule had been introduced in selected States, as only 13.5 million of the required 47.42 million doses of the inactivated poliovirus vaccine had been assured. Legacy planning was underway to ensure that the investments made towards poliomyelitis eradication would benefit other health initiatives.

The representative of MAURITANIA said that considerable efforts had been made to stop the poliovirus outbreaks that had occurred in 2009 and 2010 in his country, including carrying out supplementary immunization activities and improving surveillance for acute flaccid paralysis. The switch from trivalent to the bivalent oral poliovirus vaccine in April 2016 had been a success. Response capacities should be strengthened to prepare for the potential reimportation of the virus. Immunization systems and surveillance efforts should also be strengthened, and sufficient supply of vaccines must be guaranteed.

The representative of CHAD said that his country had been free of wild poliovirus for nearly four years, thanks to supplementary immunization activities, efforts to strengthen the cold chain through the introduction of solar technology, and building human resources capacity. Innovative strategies included the coordination with the ministry of agriculture of vaccinations of nomadic children and livestock. The trivalent oral poliovirus vaccine had been replaced by the bivalent vaccine, and inactivated poliovirus vaccine had been introduced. Challenges still remained in terms of funding for surveillance and intensified immunization activities. He urged the Secretariat to ensure successful polio legacy planning.

The observer of CHINESE TAIPEI said that the transition from oral poliovirus vaccine to the inactivated poliovirus vaccine had been carried out in 2012. All vaccine-derived polioviruses and oral poliovirus vaccines containing the type 2 component stored in laboratories had been destroyed. Surveillance systems were in place to maintain high immunization coverage and a poliomyelitis-free

status. He appealed to the Secretariat to ensure the supply of the inactivated poliovirus vaccine and to support the sustainability of immunization programmes.

The observer of the INTERNATIONAL FEDERATION OF RED CROSS AND RED CRESCENT SOCIETIES acknowledged that considerable obstacles remained in the way of poliomyelitis eradication in Afghanistan and Pakistan, namely the safety of frontline workers and the immunization coverage of children living in remote communities and areas of conflict. The Red Crescent Societies and volunteers in those two countries were working to increase immunization coverage of those children and ensure access to routine childhood vaccines. He advocated applying the lessons learned from poliomyelitis eradication to other global health priorities.

The representative of the ORGANISATION OF ISLAMIC COOPERATION, speaking at the invitation of the CHAIRMAN, said that her organization remained committed to poliomyelitis eradication and was working closely with several partners to that end. She commended the globally synchronized switch to bivalent oral poliovirus vaccine and encouraged Member States to intensify routine immunization campaigns. The lack of adequate supplies of inactivated poliovirus vaccine had been communicated to her organization's Vaccine Manufacturers Group, and steps would be taken to mitigate the risks associated with the shortage.

The representative of the GAVI ALLIANCE, speaking at the invitation of the CHAIRMAN, said that challenges still remained to the global eradication of poliomyelitis, as evidenced by recent detection of vaccine-derived poliovirus in environmental specimens in previously polio-free countries. The GAVI Alliance had worked closely with the Global Polio Eradication Initiative to facilitate the introduction of inactivated poliovirus vaccine into routine immunization programmes worldwide. The global shortage of inactivated poliovirus vaccine raised concerns about the potential re-emergence of polioviruses. Attention should be given to legacy planning to ensure that immunization coverage would not be adversely affected as funding declined for poliomyelitis programmes, and that assets could be used for other public health interventions. Discussions on how to leverage poliomyelitis assets and personnel for routine immunization would be particularly important in priority countries that had human resources funded either by the GAVI Alliance or the Global Polio Eradication Initiative.

The representative of ROTARY INTERNATIONAL, speaking at the invitation of the CHAIRMAN, praised the global switch from trivalent to bivalent oral poliovirus vaccine. However, key challenges remained. Transmission of poliovirus in Pakistan and Afghanistan had to be stopped and he encouraged a continued focus in those countries to reach every child, recognizing the dedication of frontline workers. An additional US\$ 1500 million was needed in the period until 2019 to maintain high levels of immunization and surveillance. The physical and intellectual assets resulting from 30 years of eradication efforts must be capitalized upon to benefit broader public health priorities.

The representative of the GLOBAL HEALTH COUNCIL, speaking at the invitation of the CHAIRMAN, said that urgent attention must be paid to sustaining the public health gains made by poliomyelitis eradication programmes, as well as extending immunization coverage, improving the planning and supply of vaccines, and developing a safer version of the oral poliovirus vaccine, with less potential to cause vaccine-derived polioviruses. Human resources, facilities and processes funded directly by the Global Polio Eradication Initiative should be transferred to other health service areas, such as immunization, surveillance, and emergency response. WHO should work with countries to develop detailed strategies to maintain poliomyelitis-free status, and ensure the effective management of assets and resources following global eradication. She also recommended that WHO consult with major donors to map donor-supported activities that could be continued when eradication programmes came to an end.

The DIRECTOR (Polio Eradication) said that, thanks to the extraordinary efforts of the coalition of Member States in applying the Polio Eradication and Endgame Strategic Plan 2013–2018, the world was closer than ever to eradicating poliomyelitis, and he commended efforts in Pakistan and Afghanistan. Wild poliovirus type 2 had been declared eradicated, no case of wild poliovirus type 3 had been detected in three years, and only type 1 was circulating in two countries. It was therefore vital to prevent cases of vaccine-derived poliomyelitis, and to maintain high levels of acute flaccid paralysis and environmental surveillance. The current epidemiology constituted a Public Health Emergency of International Concern for countries affected by wild poliovirus and those in which vaccine-derived poliovirus was circulating.

Regarding the update requested on the global coordinated switch to bivalent oral poliovirus vaccine, 147 out of 155 Member States had submitted validation reports to regional offices. Validation by the remaining eight Member States was ongoing and the reports would be sent shortly. There was no shortage of bivalent oral poliovirus vaccines. However, stocks of inactivated poliovirus vaccines were insufficient, as the vaccine industry had been unable to scale up production in line with the speed at which countries had committed to introduce the vaccine. Consequently, 45 countries would have to wait until 2017 for access. The allocation of the vaccines had been prioritized for countries at the highest risk of an emergence of vaccine-derived type 2 poliovirus. However, there was a global stockpile of monovalent type 2 oral poliovirus vaccines, which could be deployed quickly in the event of an outbreak in those countries.

Every effort was being made to increase production of inactivated poliovirus vaccines, including work to facilitate and support technology transfer for vaccine production. The possibility of stretching the supply of inactivated poliovirus vaccines had been explored, although one of the solutions found, which involved administering two fractional doses intradermally, required more thorough planning and greater capacity among the health workforce. The Secretariat would work with Member States to accelerate the containment of poliovirus in vaccine-production facilities and laboratories, and address the concerns raised about the shared timelines.

It was time to begin planning ahead to ensure that the investments made in poliomyelitis eradication would not be lost and were used effectively to support routine immunization and emergency responses, among other public health priorities. A detailed budget for the Global Polio Eradication Initiative had already been made available to all the Member States receiving support and was available online.

The Committee noted the report.

2. PROMOTING HEALTH THROUGH THE LIFE COURSE: Item 13 of the agenda (continued)

Operational plan to take forward the Global Strategy for Women's, Children's and Adolescents' Health: Item 13.3 of the agenda (continued from the third meeting) (document A69/16)

The CHAIRMAN recalled that a draft resolution on committing to implementation of the Global Strategy for Women's, Children's and Adolescents' Health had been introduced at the third meeting of the Committee. He informed the Committee that the numbering of the operative paragraphs in that draft resolution was incorrect, and the paragraph that began "INVITES Member States" should have been numbered as paragraph (OP) 1, and the two subsequent operative paragraphs should therefore be renumbered as paragraphs (OP) 2 and (OP) 3, respectively.

The representative of URUGUAY read out two amendments to the draft resolution agreed informally by several Member States. In renumbered operative paragraph 1(2) he proposed replacing

the words “upon their request” with “as appropriate”. In renumbered operative paragraph 3(2), the word “funds,” should be added before the words “partners and stakeholders”.

The representative of PANAMA said that her Government was striving to overcome health challenges and inequalities through the implementation and revision of legal frameworks, national initiatives and intersectoral actions on poverty reduction, vulnerable groups and sexual and reproductive health, including a master plan on health in infancy, childhood and adolescence, which sought to provide universal access to integrated health care.

The representative of ZAMBIA called for comprehensive accountability frameworks and the strengthening of health information systems to monitor programmes and levels of integration, as part of the Global Strategy. Her Government would prioritize development of a health financing strategy, in order to progressively increase the allocation of domestic resources and attain the national goals for women’s, children’s and adolescents’ health. She supported the draft resolution.

The representative of CAMEROON highlighted the achievements of her Government in relation to implementation of the Global Strategy, including the revision of the national health sector strategy and development of a financing strategy, as well as seeking investment for reproductive, maternal, newborn, child and adolescent health under the Global Financing Facility in support of Every Woman, Every Child. She supported the draft resolution.

The representative of PORTUGAL said that her Government was committed to implementing the Global Strategy and asked that her country be added to the list of sponsors of the draft resolution.

The representative of BRAZIL said that, although the Global Strategy’s focus on conflict situations and fragile States was important, it did not encompass the breadth of the 2030 Agenda for Sustainable Development. The coordinated multisectoral actions and multistakeholder engagement required to implement the Global Strategy should remain within a United Nations framework. Governments should ensure accountability, and develop progress indicators and programmatic guidance. The Paris Declaration and Accra Agenda for Action were not universal and many Member States used other equally valid frameworks for development cooperation, principles and actions.

The representative of JAMAICA said that several actions had been taken to combat problems related to adolescent health in Jamaica, including the establishment of an adolescent policy working group comprising members of civil society and other ministries, and the formulation of a policy to reintegrate teenage mothers into the formal school system.

The representative of PAKISTAN said that his Government had developed a national action plan, based on the Global Strategy, to address the slow progress made regarding maternal, newborn and child health and nutrition. Strengthened health systems staffed with adequately-skilled health workers were required to significantly improve and maintain access for women and children to affordable health care. The work of all health-sector partners should be aligned with government priorities, and involve concerted efforts to promote human rights, gender equality and poverty reduction.

The representative of REPUBLIC OF KOREA emphasized that a continuous approach was needed for relief efforts and development projects that benefited women, children and adolescents. In that regard, her Government had launched an initiative on health and education for disadvantaged girls in developing countries, and would contribute US\$ 200 million to that project over 5 years.

The representative of NIGER said that his country had made major progress towards improving maternal and child health, including the implementation of a road map to reduce maternal and neonatal mortality, and a maternal death surveillance and response programme.

The representative of INDONESIA informed the Committee of several of her Government's initiatives for attaining the Millennium Development Goal targets and implementing the Global Strategy, such as a strategic plan to reduce maternal and neonatal mortality, and a commitment to extending universal health coverage to all Indonesians by 2019.

The representative of the RUSSIAN FEDERATION drew attention to some of the action taken on women's, children's and adolescents' health in her country, such as universal access to free health care, the construction of perinatal centres and the development of health prevention programmes. The Global Strategy could only be implemented through an intersectoral and interdisciplinary approach.

The meeting rose at 17:30.

NINTH MEETING

Thursday, 26 May 2016, at 18:00

Chairman: Mr M. BOWLES (Australia)

later: Ms T. KOIVISTO (Finland)

PROMOTING HEALTH THROUGH THE LIFE COURSE: Item 13 of the agenda (continued)

Operational plan to take forward the Global Strategy on Women's, Children's and Adolescents' Health: Item 13.3 of the agenda (document A69/16) (continued)

The representative of COSTA RICA took note of the report and encouraged Member States to continue strengthening their national strategies to reduce maternal and child mortality and stop preventable maternal and child deaths. It was important not to lose sight of the human rights perspective and the need for universal healthcare services in strategies to promote women's, children's and adolescents' health. Given the complexity of the issue, collective and multisectoral action was necessary, in which the responsibilities of key actors were clearly defined.

The observer of CHINESE TAIPEI endorsed the operational plan to take forward the Global Strategy for Women's, Children's and Adolescents' Health and the proposed milestones for implementation for 2016–2017 and 2018–2020. She welcomed the draft resolution. The importance and urgency of applying a Health in All Policies approach to strengthening the well-being of women, children and adolescents was understood and steps to address health inequalities had been taken. However, more work was needed on empowerment and strengthening health literacy.

The observer of the INTER-PARLIAMENTARY UNION said that the Inter-Parliamentary Union was committed to providing support to national parliaments to enable them to deliver better health outcomes in the spirit of the Global Strategy and the Declaration of the Fourth World Conference of Speakers of Parliament. In particular, it would help parliaments to enhance accountability, carry out their oversight functions with the aim of turning global commitments into national action and strengthen legislative frameworks and budget advocacy. It would also facilitate exchanges among parliaments at the regional and global levels to ensure that good practices were shared. The Inter-Parliamentary Union's Advisory Group on HIV/AIDS and Maternal, Newborn and Child Health would track progress towards meeting those commitments.

The representative of the GLOBAL HEALTH COUNCIL, speaking at the invitation of the CHAIRMAN, said that the inclusion of adolescents in the Global Strategy would contribute to the development of comprehensive healthcare systems that met the needs of previously under-served populations, including young people. It was important to treat young people as partners in the development of policies and programmes under the Global Strategy. Health systems should respond to the specific needs of children, ensuring that they had access to affordable and quality-assured medicines and technologies. An improved system to collect and monitor data on mortality in children and adolescents, disaggregated by age and sex from birth to 24 years, was needed, including data on noncommunicable diseases. Such a system was essential for effective planning and to ensure equitable access to care.

The representative of the INTERNATIONAL COUNCIL OF NURSES, speaking at the invitation of the CHAIRMAN, expressed strong support for the alignment of the Global Strategy with the life-course approach to health and the inclusion in the Strategy of adolescent health, an area in which she encouraged the Secretariat and Member States to work together to strengthen the knowledge base. By intervening early and in an integrated manner, noncommunicable diseases, malnutrition and birth-related complications could be prevented. She appreciated that the Strategy identified the need for resilient, effective and efficient health systems that were equipped with the necessary materials and with trained healthcare professionals. That would, however, require effective planning and financing.

The representative of the INTERNATIONAL PEDIATRIC ASSOCIATION, speaking at the invitation of the CHAIRMAN, said that social injustice must be addressed for a stronger, more peaceful and sustainable society. Governments must reduce structural inequities in family income, implement a comprehensive approach to early child development and protection spanning from infancy to adolescence, invest in health, education and family support services, ensure all essential services were accessible and affordable, implement the Global Strategy and ensure effective data collection that would be used in evidence-based policies and programmes.

The representative of the INTERNATIONAL FEDERATION OF MEDICAL STUDENTS' ASSOCIATIONS, speaking at the invitation of the CHAIRMAN, commended the Global Strategy and highlighted the importance optimizing health across the life course. That could be achieved only by tackling the inequities that made women, children and adolescents prone to poorer health outcomes and by ensuring that efforts were focused on reducing maternal, newborn and child mortality among fragile populations. An efficient, multisectoral and collective approach as well as a strong sense of accountability would be imperative in implementing the Strategy. Specifically, Member States should ensure access to family planning and contraception services and promote non-judgemental healthcare that respected the rights of women, children and adolescents. Furthermore, the entire health workforce, including students, should undergo comprehensive evidence-based training on sexual and reproductive health and rights.

The representative of the INTERNATIONAL PLANNED PARENTHOOD FEDERATION, speaking at the invitation of the CHAIRMAN, welcomed the operational plan and the recognition of the challenges facing implementation of the Global Strategy, particularly in humanitarian situations. Given that half of maternal, newborn and child deaths occurred in fragile settings, services were needed to enable women to deliver safely and with dignity, protect themselves from HIV and to treat the consequences of sexual violence. Indeed, sexual and reproductive health services should be included in the minimum package of services offered when providing humanitarian assistance. Young people should be active stakeholders in the development, implementation and evaluation of country programmes and partnerships should be established to ensure that adolescents were aware of their health rights. She welcomed the recommendation to prioritize enhanced accountability mechanisms and encouraged the participation of civil society in accountability processes. Adequate safeguards must be introduced against increased out-of-pocket payments, which would have a disproportionately negative impact on the poorest and most vulnerable people, in order to ensure that a shift to domestic resources did not amount to charging women for access to life-saving health services.

The representative of THE SAVE THE CHILDREN FUND, speaking at the invitation of the CHAIRMAN, supported the draft resolution. New commitments under the Strategy must address inequities in access to essential sexual, reproductive, maternal, newborn, child and adolescent health care as well as ensure the participation of women, children and adolescents in decisions that affected their health. He called on Member States and other partners to guarantee an essential package of sexual, reproductive, maternal, newborn, child and adolescent healthcare services with a focus on

primary health care; ensure that time-bound equity targets were in place to boost progress among the poorest and most marginalized populations; and improve the quality of care in health facilities.

The representative of the UNION FOR INTERNATIONAL CANCER CONTROL, speaking at the invitation of the CHAIRMAN, called for concerted efforts to reach the noncommunicable disease-related targets in the Global Strategy, given that millions of lives were claimed and disrupted by those diseases each year. Expressing support for the accountability measures for tracking progress towards achieving the goals and the targets of the Strategy, she called on Member States to ensure integrated accountability; develop sustainable strategies to finance health accountability that maximized the use of domestic resources; strengthen the capacity of the global Health Data Collaborative to include disaggregated noncommunicable disease data; and promote and ensure the meaningful engagement of civil society in supporting country-led implementation and accountability. She expressed support for the draft resolution.

The representative of the WORLD HEART FEDERATION, speaking at the invitation of the CHAIRMAN, welcomed the draft resolution and the report and commended the Global Strategy's target of reducing noncommunicable diseases by one third by 2030. To achieve that target, it was important to draw attention to rheumatic heart disease, which disproportionately affected women, children and adolescents. Action recommended to combat rheumatic heart disease included: monitoring maternal, child and adolescent health outcomes using national registers; implementing selected interventions from the Three Stage Integrative Pathway Search framework; and orienting universal health coverage priorities towards inclusivity and financial protection.

The representative of WORLD VISION INTERNATIONAL, speaking at the invitation of the CHAIRMAN, said that it was necessary to invest in local leadership and to ensure the participation of affected people in the design of health solutions, including in fragile and conflict settings and emergencies. In particular, more attention must be paid to participatory monitoring and accountability mechanisms at all levels and in all contexts, in order to ensure that global goals translated into concrete local change. She called on Member States to adopt the resolution.

The ASSISTANT DIRECTOR-GENERAL (Family, Women's and Children's Health), responding to comments, noted with appreciation the unprecedented level of political commitment to the Global Strategy and the draft resolution. Many countries had made very specific commitments and their progress in implementation would be tracked by WHO. It was clear that a high degree of innovation would be required to apply the new focus on adolescent health and on the fragile contexts and settings in which women, children and adolescents were often left behind. United Nations agencies had been called on to provide technical assistance in implementing the Strategy and to explore new ways of doing so, including through South-South and triangular cooperation. Reference had been made to the need for evidence-based guidelines. She recalled that implementation also involved accountability, the mechanisms of which were being put in place, including through the Independent Accountability Panel. Nongovernmental organizations had referred to citizen engagement and dialogue as a mechanism to reinforce accountability.

At the invitation of the CHAIRMAN, the SECRETARY read out the amendments to the draft resolution: at the end of renumbered operative paragraph 1(2), the words "upon their request" should be replaced by "as appropriate"; and, in renumbered operative paragraph 3(2), the word "funds," should be added before the words "partners and stakeholders".

The draft resolution, as amended, was approved.¹

Multisectoral action for a life course approach to healthy ageing: draft global strategy and plan of action on ageing and health: Item 13.4 of the agenda (document A69/17)

The CHAIRMAN drew attention to a draft resolution entitled: “The global strategy and action plan on ageing and health 2016–2020: towards a world in which everyone can live a long and healthy life”, submitted by the delegations of Argentina, Australia, Colombia, Denmark, Ecuador, Finland, France, Germany, Japan, Luxembourg, Monaco, the Netherlands, Norway, Panama, Portugal, Thailand and the United States of America, which read:

The Sixty-ninth World Health Assembly,

(PP1) Having considered the report on multisectoral action for a life course approach to healthy ageing: draft global strategy and plan of action on ageing and health;²

(PP2) Recalling resolution WHA52.7 (1999) on active ageing and resolution WHA58.16 (2005) on strengthening active and healthy ageing, both of which called upon Member States to take measures that ensure the highest attainable standard of health and well-being for the rapidly growing numbers of older persons;

(PP3) Recalling further United Nations General Assembly resolution 57/167 (2002), which endorsed the Madrid International Plan of Action on Ageing, 2002, as well as other relevant resolutions and other international commitments related to ageing;

(PP4) Having considered resolution WHA65.3 (2012) on strengthening noncommunicable disease policies to promote active ageing, which notes that as noncommunicable diseases become more prevalent among older persons, there is an urgent need to prevent disabilities related to such diseases and to plan for long-term care;

(PP5) Having also considered resolution WHA67.19 (2014) on strengthening of palliative care as a component of comprehensive care throughout the life course;

(PP6) Recalling resolution WHA64.9 (2011) on sustainable health financing structures and universal coverage, which calls for investing in and strengthening health systems, in particular primary health care and services, including preventive services, adequate human resources for health and health information systems, in order to ensure that all citizens have equitable access to health care and services;

(PP7) Welcoming the 2030 Agenda for Sustainable Development,³ which includes an integrated, indivisible set of global goals for sustainable development that offer the platform to deal with the challenges and opportunities of population ageing and its consequences in a comprehensive manner, pledging that no one will be left behind;

(PP8) Noting that populations around the world, at all income levels, are rapidly ageing; yet, that the extent of the opportunities that arise from older populations, their increasing longevity and active ageing will be heavily dependent on good health;

(PP9) Noting also that healthy ageing is significantly influenced by social determinants of health, with people from socioeconomically disadvantaged groups experiencing markedly poorer health in older age and shorter life expectancy;

(PP10) Further noting the importance of healthy, accessible and supportive environments, which can enable people to age in a place that is right for them and to do the things they value;

¹ Transmitted to the Health Assembly in the Committee’s third report and adopted as resolution WHA69.2.

² Document A69/17.

³ United Nations General Assembly resolution 70/1 (2015) – Transforming our world: the 2030 Agenda for Sustainable Development, see http://www.un.org/ga/search/view_doc.asp?symbol=A/RES/70/1 (accessed 23 May 2016).

(PP11) Recognizing that older populations make diverse and valuable contributions to society and should experience equal rights and opportunities, and live free from age-based discrimination;

(PP12) Welcoming WHO's first Ministerial Conference on Global Action Against Dementia (Geneva, 16 and 17 March 2015), taking note of its outcome, and welcoming with appreciation all other international and regional initiatives aimed at ensuring healthy life for older persons;

(PP13) Welcoming also the *World report on ageing and health*,¹ that articulates a new paradigm of Healthy Ageing and outlines a public health framework for action to foster it;

(PP14) Recognizing the concept of Healthy Ageing, defined as the process of developing and maintaining the functional ability² that enables well-being in older age;

(PP15) Having considered the draft global strategy and action plan on ageing and health in response to decision WHA67(13) (2014), that builds on and extends WHO's regional strategies and frameworks³ in this area,

(OP) 1. ADOPTS the Global strategy and action plan on ageing and health;⁴

(OP) 2. CALLS ON partners, including international, intergovernmental and nongovernmental organizations, as well as self-help and other relevant organizations:

- (1) to support and contribute to the accomplishment of the Global strategy and action plan on ageing and health and in doing so, to work jointly with Member States and with the WHO Secretariat where appropriate;
- (2) to improve and support the well-being of older persons and their caregivers through adequate and equitable provision of services and assistance;
- (3) to support research and innovation and gather evidence on what can be done to foster healthy ageing in diverse contexts, including increased awareness of the social determinants of health and their impact on ageing;
- (4) to support the exchange of knowledge and innovative experiences, including through North–South, South–South, and triangular cooperation, regional and global networks;
- (5) to actively work on advocacy for healthy ageing over the life course and combat age-based discrimination;

(OP) 3. URGES Member States:

- (1) to implement the proposed actions in the Global strategy and action plan on ageing and health, through a multisectoral approach, including establishing national plans or mainstreaming those actions across government sectors, adapted to national priorities and specific contexts;

¹ World report on ageing and health, Geneva: World Health Organization; 2015.

² This functional ability is determined by the intrinsic capacity of the individual, the environments they inhabit and the interaction between them. Moreover, Healthy Ageing is a process that spans the entire life course and that can be relevant to everyone, not just those who are currently free of disease.

³ Region of the Americas: Plan of Action on the Health of Older Persons, Including Active and Healthy Aging (resolution CD49.R15 (2009)); South-East Asia Region: Regional strategy for healthy ageing (2013–2018); European Region: Strategy and action plan for healthy ageing in Europe, 2012–2020 (resolution EUR/RC62/R6 (2012)); Eastern Mediterranean Region: The strategy for active, healthy ageing and old age care in the Eastern Mediterranean Region 2006–2015; Western Pacific Region: Regional framework for action on ageing and health in the Western Pacific (2014–2019). A regional strategy is in preparation in the African Region.

⁴ See document A69/17, Annex.

- (2) to establish a focal point and area of work on ageing and health and to strengthen the capacity of relevant government sectors to deal with the healthy ageing dimension in their activities through leadership, partnerships, advocacy and coordination;
- (3) to support and contribute to the exchange between Member States at global and regional levels of lessons learned and innovative experiences, including actions to improve measurement, monitoring and research of healthy ageing at all levels;
- (4) to contribute to the development of age-friendly environments, raising awareness about the autonomy and engagement of older people, through a multisectoral approach;

(OP) 4. REQUESTS the Director-General:

- (1) to provide technical support to Member States to establish national plans for healthy ageing, develop health and long-term care systems that can deliver good-quality integrated care; implement evidence-based interventions that deal with key determinants of healthy ageing; and strengthen systems to collect, analyse, use and interpret data on healthy ageing over time;
- (2) to implement the proposed actions for the Secretariat in the global strategy and action plan on ageing and health in collaboration with other bodies of the United Nations system;
- (3) to leverage the experience and lessons learned from the implementation of the global strategy and action plan on ageing and health in order to better develop a proposal for a Decade of Healthy Ageing 2020–2030, with Member States and inputs from partners, including United Nations agencies, other international organizations, and nongovernmental organizations;
- (4) to prepare a global status report on healthy ageing for the Seventy-third World Health Assembly, reflecting agreed standards and metrics and new evidence on what can be done in each strategic theme, to inform and provide baseline data for a Decade of Healthy Ageing 2020–2030;
- (5) to convene a forum to raise awareness of Healthy Ageing and strengthen international cooperation on actions outlined in the Global strategy and action plan on ageing and health;
- (6) to develop in cooperation with other partners a global campaign to combat ageism in order to add value to local initiatives and to achieve an ultimate goal of enhancing the day-to-day experience of older people and to optimize policy responses;
- (7) to continue to develop the WHO Global Network of Age-friendly Cities and Communities as a mechanism to support local multisectoral action on healthy ageing;
- (8) to support research and innovation to foster healthy ageing, including developing:
 - (i) evidence-based tools to assess and support clinical, community, and population-based efforts to enhance intrinsic capacity and functional ability; and
 - (ii) cost-effective interventions to enhance functional ability of people with impaired intrinsic capacity;
- (9) to report on mid-term progress on implementation of the global strategy and action plan on ageing and health, reflecting agreed quantifiable indicators, standards and metrics and new evidence on what can be done in each strategic objective, to the Seventy-first World Health Assembly.

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

Resolution: Multisectoral action for a life course approach to healthy ageing: draft global strategy and plan of action on ageing and health			
A. Link to the general programme of work and the programme budget			
1. Please indicate to which impact and outcome in the Twelfth General Programme of Work, 2014–2019 and which output in the Programme budget 2016–2017 this draft resolution will contribute if adopted. Category 3, Promoting health through the life course: Outcome 3.2 ageing and health, and outputs 3.2.1, 3.2.2 and 3.2.3.			
2. If there is no link to the results as indicated in the Twelfth General Programme of Work, 2014–2019 and the Programme budget 2016–2017, please provide a justification for giving consideration to the draft resolution. Not applicable.			
3. What is the proposed timeline for implementation of this resolution? 2016–2020 in line with Global Strategy and Action Plan on Ageing and Health <i>If the timeline stretches to future programme budgets, please ensure that further information is provided in the costing section.</i>			
B. Budgetary implications of implementation of the resolution			
1. Current biennium: estimated budgetary requirements, in US\$ million			
Level	Staff	Activities	Total
Country offices	4.00	6.00	10.00
Regional offices	2.88	4.32	7.20
Headquarters	7.68	5.12	12.80
Total	14.56	15.44	30.00
1(a) Is the estimated budget requirement in respect of implementation of the resolution fully included within the current programme budget? (Yes/No) Yes.			
1(b) Financing implications for the budget in the current biennium: – How much is financed in the current biennium? US\$ 13.5 million – What are the gaps? US\$ 16.5 million – What action is proposed to close these gaps? The gap will be addressed through coordinated resource mobilization efforts, including the financing dialogue, for possible financing by voluntary contributions.			

2. Next biennium: estimated budgetary requirements, in US\$ million			
Level	Staff	Activities	Total
Country offices	6.60	9.90	16.50
Regional offices	4.92	7.38	12.30
Headquarters	8.48	12.72	21.20
Total	20.00	30.00	50.00
2(a) Financing implications for the budget in the next biennium:			
– How much is currently financed in the next biennium?			
US\$ 10 million			
– What are the financing gaps?			
US\$ 40 million			
– What action is proposed to close these gaps?			
The gap will be addressed through coordinated resource mobilization efforts, including the financing dialogue, for possible financing by voluntary contributions.			

The representative of BURUNDI, speaking on behalf of the Member States of the African Region, said that the draft strategy was timely. The proportion of the African population over the age of 60 was growing and African health systems were not yet ready to respond: specialized services, infrastructure and training were lacking. He commended the transparent and inclusive way in which the draft global strategy on ageing and health contained in document A69/17 had been developed and said that it should be integrated with national programmes. Healthy ageing must be linked to the development of economic, social and human rights, which would strengthen the social safety net and promote the inclusion of elderly people in community life. He supported the adoption of the draft strategy and action plan.

The representative of PANAMA recalled that her country was a sponsor of the draft resolution and thus supported the action plan on healthy ageing. Fighting discrimination would be crucial. Her Government's response to demographic transition included palliative care and promoting a healthy diet. Short-, medium- and long-term national plans were needed and should take the indicators from the draft strategy and action plan into account.

The representative of PARAGUAY said the draft strategy and action plan were in line with existing legislation in her country. Their implementation was vital for Paraguay, which was in rapid demographic transition. Implementing the draft strategy's five strategic objectives would help maximize the functional ability of the whole population, especially older people. Increased public-private sector cooperation was needed to help Paraguay build its professional and academic capacities, particularly in geriatrics and gerontology. She fully supported the draft strategy and draft resolution.

The representative of AUSTRALIA welcomed the draft strategy and action plan and acknowledged the global and regional work being done to encourage multisectoral action on healthy ageing and WHO's important role in that respect. Population ageing was a particular challenge in the Western Pacific Region, and he hoped to share experiences on how to adapt health care systems and ensure their sustainability. As a sponsor of the draft resolution, Australia strongly supported the draft strategy and action plan.

The representative of MONACO said that the intersectoral approach of the draft strategy and its encouragement of stakeholder participation in focusing on the needs and rights of older populations

were in tune with the Sustainable Development Goals. A quarter of Monaco's population was over 65 years of age and her Government was committed to providing that population group with medical care and to coordinating actions to ensure their independence and well-being. Monaco fully supported the adoption of the draft strategy and action plan.

Ms Koivisto took the Chair.

The representative of the PHILIPPINES noted with satisfaction that the draft strategy drew on existing international instruments and that Member States and other stakeholders had been widely consulted during its development. The proposed milestones and action plan would be particularly helpful for achieving concrete progress. She endorsed the draft strategy and asked for the Philippines to be included as a sponsor of the draft resolution.

The representative of SWITZERLAND welcomed the draft strategy which would be particularly useful to Member States in the context of a globally ageing population. She drew attention to a forthcoming comparative study by her Government containing best practices for promoting and maintaining the health and well-being of older populations, which she hoped would prove useful to policy-makers. Switzerland wished to sponsor the draft resolution.

The representative of CANADA welcomed the draft strategy, supported its adoption by the Health Assembly and asked for Canada to be added as a sponsor. In particular, she supported WHO's multisectoral approach and noted that the proposed action plan was in line with Canada's efforts to address the needs of its ageing population. However, given the federal system in Canada, flexibility would be needed in implementing and reporting on the plan.

The representative of CHINA endorsed the strategic objectives in the draft strategy, particularly their acknowledgement of differing priorities and rates of demographic change between countries. Chinese national plans were in line with WHO's vision and targets. She noted that it would take varying amounts of time to achieve the targets for long-term care systems, health insurance systems and human resources. The timeline set out in paragraph 107 of document A69/17 should therefore be adapted to countries' individual development needs. She hoped that WHO would continue to provide support and guidance to Member States, to set up data-support and surveillance systems, to issue comparative studies and to share its reports.

The representative of SOUTH AFRICA welcomed the draft strategy and plan of action and approved of the human rights-based, public health approach. The emphasis on strengthening health systems and developing, deploying and managing human resources was encouraging. She therefore supported the draft strategy and recommended that Member States should implement it.

The representative of JAPAN credited his country's achievements in promoting healthy ageing to a multisectoral approach that included medical care, welfare and housing for elderly people. The draft strategy was timely, since ageing populations were an increasingly global issue. He hoped to increase cooperation with Member States and the Secretariat on developing more scientific approaches and sharing experiences and lessons learned. He drew attention to the 42nd G7 Summit which was currently taking place in Japan, at which his Government had called for an "active ageing" movement to promote a larger role for elderly people in their families and communities. He called for the adoption of the draft resolution.

The representative of COSTA RICA noted the report contained in document A69/17 and supported the draft resolution.

The representative of BRAZIL said that there was a need for investment in scientific innovation and a broader perspective on health throughout the life course. Varied policies and responses were needed, as the elderly population was heterogeneous, even within a given country. She welcomed WHO's commitment to the issue and supported the adoption of the draft strategy and draft resolution. Her country was committed to implementing policies according to the proposed timeline.

The representative of SAUDI ARABIA endorsed the draft strategy and action plan and called for their adoption. He hoped that they would help in determining the best means of improving health systems for elderly people. He called on Member States to strengthen capacities to improve health throughout the life course. He hoped that the strategy would establish indicators for monitoring and assessing the health of older persons, and underscored that Member States would need the assistance of WHO if they were to enhance training and knowledge sharing and design effective policies and oversight mechanisms to monitor the implementation of the draft strategy and action plan.

The representative of the NETHERLANDS, speaking on the behalf of the European Union and its Member States, said that Turkey, the former Yugoslav Republic of Macedonia, Serbia, Albania, Bosnia and Herzegovina, Ukraine, the Republic of Moldova and Georgia aligned themselves with his statement. He welcomed the draft strategy, particularly strategic objective 1.2 on evidence-based policies, noting that WHO and other international actors could assist in closing the current evidence gap. Helping older people participate actively in society by staying employed longer would require more flexibility in the labour market. Promoting coordination across government sectors and technologies enabling independent living would also contribute to achieving the draft strategy's goals. Older people could be a resource for society and Member States were responsible for helping those who needed support. Indeed, the focus should be on helping the most vulnerable and marginalized people and fostering gender equality. He supported the adoption of the draft resolution.

The representative of SLOVENIA said that life expectancies and the increasing proportion of older people in her country had prompted the development of a number of national programmes. The draft strategy underscored multisectoral action and engagement from various sectors and levels of government, which experience had shown to be the most effective approach. Older populations had much to contribute to society and, therefore, laws, policies and programmes must be aligned to enable their full participation. Properly reported monitoring of the different social determinants of health was also essential to moving the agenda forward. She supported the adoption of the draft strategy.

The representative of the UNITED KINGDOM OF GREAT BRITAIN AND NORTHERN IRELAND said that, although people were living longer lives, the majority of them spent their last years in suboptimal health. The draft global strategy and plan of action on ageing and health addressed many of the challenges faced by States and he commended the focus on both intrinsic and extrinsic capacity as key factors in determining the ability of older people to remain independent and engaged. Indeed, the draft strategy and action plan would empower States to formulate policy responses compatible with their particular circumstances. Supportive environments that facilitated healthy ageing could complement the intrinsic capacity of older people; in that respect, he noted that a number of cities in the United Kingdom were particularly age-friendly. He welcomed the proposal that WHO should expand and develop the global network of age-friendly cities and believed that the Organization could play a key role in fostering dementia-friendly environments.

The representative of the UNITED STATES OF AMERICA said that his country had participated in the consultative process to formulate the draft global strategy and plan of action and he welcomed the strategy's human rights-based focus. Highlighting the focus on the abuse, neglect and exploitation of older persons in the report, he encouraged WHO to consider how the strategy and plan of action could be reinforced by work already accomplished on strengthening the role of health systems in addressing violence against women and girls, with particular reference to the violence

suffered by older women. While health systems were doing a better job in dealing with the needs of older people, many still did not fully recognize or provide incentives and compensation for family and community care for older persons, which was often medically beneficial and cost effective. Older people needed housing, transportation and healthy diets, and stakeholders overseeing the implementation of the global strategy must ensure that those multisectoral aspects of healthy ageing were taken into account. Dementia was one of the major causes of disability and dependency among older persons worldwide, and he looked forward to further discussion of the subject in the following biennium.

The representative of GERMANY said that, while she welcomed the ambitious and comprehensive draft global strategy and plan of action, she would have preferred a sharper focus on disease prevention and health promotion, including the promotion of adequate exercise and healthy diets. Germany's 2015 Preventive Health Care Act sought to enhance the health of elderly persons by addressing their lifestyles and living conditions. She welcomed the definition of healthy ageing adopted by the draft strategy, its emphasis on multisectoral approaches to ageing, the importance placed on gender sensitivity and evidence-based policies, and the fact that the strategy could be amended on the basis of future studies.

The representative of the UNITED REPUBLIC OF TANZANIA said the proposed draft strategy would focus attention on the needs and rights of older persons and expand the international community's range of policy instruments that could be used to accelerate progress towards the achievement of the Sustainable Development Goals. Some 31 per cent of the United Republic of Tanzania's population of 50 million was between 10 and 24 years of age and, between 2002 and 2012, life expectancy had increased from 51 to 60 for men and from 51 to 64 for women. The country had adopted a national policy on ageing in 2003 and fully supported the adoption of the draft global strategy and plan of action.

The representative of SWEDEN said that his country wished to be added to the list of sponsors of the draft resolution.

The representative of the REPUBLIC OF KOREA said that her country had established an insurance programme in 2008 to fund long-term care for older persons and it was also seeking to expand the range of available home-care services for older persons, with a view to improving their quality of life and reducing the care burden shouldered by their families. Her Government was also promoting prevention-focused health management for older persons and strengthening the country's mechanisms to prevent, control and treat dementia.

The representative of ARGENTINA said that the draft strategy and plan of action broadened the range of instruments available to the international community to address the needs of older persons. She underscored the importance of promoting health throughout the life course, and welcomed the draft strategy and action plan's focus on the five strategic objectives. States must ensure that adequate resources were allocated to initiatives to promote healthy ageing and collaborate closely with all relevant stakeholders, including WHO, to that end.

The representative of IRAQ said that WHO should provide capacity building to local communities, which played a key role in promoting healthy lifestyles for older persons. The Organization should also promote knowledge-sharing among States on issues related to ageing, and States should seek to deal with challenges related to ageing in an environmentally friendly manner. It was also vital to combat the spread of noncommunicable diseases, inter alia, by discouraging the use of tobacco and other drugs and encouraging people to engage in physical activity and eat balanced diets. It was also necessary to promote mental health among older persons and provide those in need with psychosocial support. Primary health care centres in Iraq and geriatric departments in Iraqi

hospitals provided a range of preventive, treatment and rehabilitation services. Trained volunteers could play a vital role in promoting the health of older persons by visiting them in their homes.

The representative of VIET NAM said that, in 2014, approximately 6.4 million people, or just over 7% of his country's population, were over 64 years of age. His Government had taken a number of legislative and policy steps to help older persons live long and healthy lives, and it sought to raise awareness on the importance of healthy lifestyles. Although Viet Nam's average life expectancy of 73 years was high, people lived on average for 15.3 years with serious health complications. Noncommunicable diseases were on the rise and expenditure on health care for older persons, who consumed half of all medicines in the country, was seven to 10 times Viet Nam's expenditure on health care for young people. Meanwhile, a lack of trained personnel, including geriatric doctors and nurses, meant that Viet Nam had limited geriatric health care capacity. Addressing the material and spiritual needs of older people was an obligation and responsibility for every individual, family and society, and therefore he warmly welcomed the draft global strategy and plan of action, which would help States to promote life-long health for their citizens.

The representative of ICELAND said that the ageing of populations was a sign of States' growing prosperity and should therefore be viewed as a positive trend. Good health in old age was a very important factor that enhanced people's quality of life and sense of well-being. All societies must recognize, value and make use of the knowledge and experience of older people, which constituted a rich resource for humanity. She welcomed the focus placed by the draft global strategy and plan of action on healthy lifestyles and supportive environments for elderly persons, and its recognition that gender was a factor affecting many health-related behaviours. The draft strategy presented an opportunity to consider gender in health care planning, including in financial administration and budgeting.

The representative of INDONESIA said that many health conditions associated with ageing could be prevented or delayed if people adopted healthy behaviours. The global strategy and plan of action on ageing and health would help governments and other relevant stakeholders to ensure that people lived long and healthy lives, and would strengthen their capacity to promote the rights of older people and combat age-based discrimination. Indonesia was committed to improving the health of older persons, and had recently adopted a national action plan for healthy ageing, and a ministerial decree to enhance geriatric services in hospitals and community health centres. She hoped that Member States would be able to take the necessary measures to implement the global strategy and plan of action.

The representative of INDIA said that most health problems affecting older persons were linked to chronic conditions, including noncommunicable diseases, and that many of those diseases could be prevented or delayed if people adopted healthy lifestyles. India's national programme for the healthcare of older persons aimed to facilitate their access to preventive, curative and rehabilitative services. The Ministry of Health and Family Welfare had approved the establishment of two national centres to study ageing and regional geriatric centres were being established across the country. Furthermore, the International Institute for Population Sciences in Mumbai, in collaboration with international partners, was conducting a longitudinal ageing study to assess the health of persons aged between 45 and 60. More needed to be done to combat age-based discrimination and mental health must be recognized as a key component of healthy ageing. There was a growing need for services to address dementia. There was also a pressing need for more accurate data on older adults and to take into account gender issues. WHO must strengthen its training and exchange programmes and support Member States' efforts to formulate healthy ageing policies and programmes.

The representative of MALDIVES said that life expectancy for Maldivians had reached 76 years for men and 78 years for women. Although people were living longer, her country was witnessing an increase in the prevalence of noncommunicable diseases and therefore she welcomed the focus placed by the draft global strategy and plan of action on policies to combat them. The Government was giving priority to enhancing older persons' access to health care and ensuring that they were able to live in dignity. A national strategy on healthy ageing was being formulated and the country's primary health care system was actively promoting healthy lifestyles among older persons. Her Government fully supported the global strategy and plan of action and wished to join the sponsors of the draft resolution.

The representative of FIJI said that his Government was in the process of establishing a national multisectoral committee in order to combat and control noncommunicable diseases, which constituted the greatest threat to healthy ageing in his country, and to promote physical and mental health among the population. Fiji had also established a multisectoral National Council for Older Persons, which supported studies in the field of gerontology and was spearheading the development of geriatric care in the country.

The representative of MEXICO said that stakeholders should adopt multisectoral approaches in their efforts to promote the health of older persons. In particular, action must be taken to reduce the prevalence of noncommunicable diseases and encourage people to adopt healthy lifestyles. The five strategic objectives contained in the draft strategy and action plan would further States' efforts to achieve the Sustainable Development Goals and, to implement the strategy successfully, stakeholders must enjoy access to accurate data disaggregated by age and gender. His Government had established a programme to enhance care for elderly persons and held a national health week on older persons to share best practices on conditions affecting ageing populations, such as arthritis, osteoporosis and depression. It was vital to involve communities and public and private sector stakeholders in all efforts to promote the health of older persons.

The representative of MALTA said that her country had long promoted the health and well-being of older persons. Indeed, Malta hosted the United Nations International Institute on Ageing, and the Department of Gerontology at the University of Malta was one the leading international centres for the study of gerontology and geriatrics. In 2013, Malta had launched its National Strategic Policy for Active Ageing, which promoted older persons' participation in the labour market and society and sought to enhance their capacity to live independently. Furthermore, Malta had recently adopted two key laws on ageing, namely the Healthy Lifestyle Promotion and Care of Non-Communicable Diseases Act, and the Commissioner for Older Persons Act, which provided for the appointment of a Commissioner to promote and safeguard the interests and rights of older persons. It was vital that every strategy to promote healthy ageing placed older persons at its core; they must be empowered to voice their needs and their expectations and aspirations must guide implementation of policies designed to uphold their interests.

The representative of the DEMOCRATIC PEOPLE'S REPUBLIC OF KOREA, speaking on behalf of the Member States of the South-East Asia Region, said that the increasing number of older persons was placing considerable strain on States' health sectors. The countries of the Region therefore fully supported the adoption of the draft global strategy and plan of action on ageing and health, which would strengthen States' efforts to address the growing challenges they faced, and would complement and build upon the Regional strategy for healthy ageing 2013–2018, developed by the WHO Regional Office for South-East Asia. It was important to strengthen South-East Asia's cultural norms, which promoted respect for and valued the contribution to society made by elderly persons. The draft global strategy and plan of action set forth clear objectives for Member States, the Secretariat, and relevant national and international stakeholders and would reinforce their commitment to promote the health and well-being of older persons.

The representative of the PLURINATIONAL STATE OF BOLIVIA said that his Government had implemented a series of economic and social policies to foster sustainable growth, in accordance with the philosophy of “living well.” Measures had been taken to ensure a universal, comprehensive, intracultural and intercultural health service that focused on individuals and communities, including the development of an action plan for an indigenous health network and the establishment of free health care for older adults.

The representative of NORWAY said that smarter and more innovative ways of designing and organizing societies were required in order to rethink ageing and the participation of older persons. Inspiration could be drawn from the European Innovation Partnership on Active and Healthy Ageing. Further promotion of public health and the application of a Health in All Policies approach were vital to ensure healthy and active ageing. He agreed that the draft global strategy could have focused more on primary prevention. The strategy should also take into account the need to design human resources policies that provided incentives for older adults to prolong their participation in the health workforce. Increased longevity meant that expectations concerning the length of working lives needed to change.

The representative of NAMIBIA said that a number of social protection measures to ensure dignified and healthy lives for older adults had been introduced in her country, such as a universal pension scheme, free health care and low-income housing, and a national study had been carried out on the status and living conditions of older persons. Her Government wished to be added to the list of sponsors of the draft resolution.

The representative of TIMOR–LESTE said that her Government had implemented, with support from the Regional Office for South-East Asia and country offices, a national strategic plan that involved the introduction of a healthy ageing community-based health care programme and the strengthening of primary health care for older adults. She requested WHO to continue to provide support, including for the application of the global strategy and action plan in her country.

The representative of THAILAND said that ageing-related policies in Thailand were based on the Asian cultural concept that older persons were the most valuable and experienced citizens and should be cared for by the whole of society and by their families. Such policies therefore not only provided universal health coverage, but also financial, social and spiritual support. A strong, well-trained workforce, including family caregivers and community volunteers, was critical for the provision of health services for older persons.

The representative of the RUSSIAN FEDERATION said that her Government had implemented several federal laws and initiatives to reduce tobacco and alcohol consumption, promote healthy lifestyles, and increase intersectoral cooperation in the prevention of noncommunicable diseases. To cope with the medical and economic burden of an ageing population, it was pursuing public-private partnerships to develop health infrastructure, improve scientific and technological training, and create preventive programmes.

The representative of BANGLADESH said that a national policy for elderly persons had been developed in his country. He welcomed the draft strategy’s emphasis on the need for long-term care and the specialized human resources required for ageing people. His Government intended to strengthen capacity for research on innovative health care interventions, medical devices and medicines, and build a global repository system for innovative research findings. The introduction of special health protection schemes could help prevent financial hardship in older populations.

The representative of ITALY, while welcoming the report, called for a better balance between the clinical and rehabilitative aspects of the document and the more neglected issues of prevention and frailty. Frailty could be actively identified and prevented through its association with conditions

common in older persons, such as obesity and diabetes. Vaccination coverage for older adults should also be considered. Emphasis should be placed on the link between poverty, neglect, unhealthy diets and economic crises, and the decreasing resilience of the ageing population. The increasing life expectancy of populations could pose serious challenges due to the deteriorating conditions for older persons, unless determined society-wide efforts were made to redefine priorities.

The observer of CHINESE TAIPEI said that the WHO initiative and guidelines on age-friendly cities should be revised to take into account rural-built environments. Older people living in rural communities tended to have a lower socioeconomic status. It was hoped that they would not be left behind with respect to the global initiative on active ageing. A policy framework on an ageing society, a white paper and an implementation plan had been drawn up in Chinese Taipei in line with related WHO concepts and strategies. Age-friendly initiatives had been implemented, with the active engagement of older people. A programme on age-friendly health care organizations had been launched, in order to integrate universal, comprehensive health promotion, protection and prevention measures into clinical services for older people. A framework based on the Organization's age-friendly principles and standards for health promotion in hospitals had been established. As part of that work, over 200 organizations had been recognized as "age friendly". A multisectoral monitoring framework was in the process of being established in Chinese Taipei, with a view to achieving an age-friendly society.

The observer of the INTERNATIONAL FEDERATION OF RED CROSS AND RED CRESCENT SOCIETIES welcomed the report and the draft global strategy and action plan, with its emphasis on empowerment and respect for human dignity and combating discrimination, stigmatization and ageism. The latter was a major barrier to healthy ageing and to the implementation of the global strategy and action plan. It was important to combat age-based discrimination, in order to change attitudes and behaviour that had a negative impact on the health and well-being of older people. Age-based discrimination included a lack of adequate services and discriminatory stereotypes and attitudes, as well as failure to consult older people as part of the policy development process and on the delivery of health services. She called on Member States to endorse and implement the global strategy and action plan, including by adopting legislation on age-based discrimination, and to make a commitment to providing inclusive and equitable health and social care services, including in humanitarian situations, on the basis of robust, age-inclusive data.

The representative of ALZHEIMER'S DISEASE INTERNATIONAL, speaking at the invitation of the CHAIRMAN, said that her organization supported the report and the draft global strategy and plan of action. Ageing was one of the major non-modifiable risk factors for dementia, and many issues addressed in the action plan would help to support people living with dementia, their families and health professionals. It was essential to recognize that many older people had multiple chronic conditions that were poorly managed and policies on ageing could help to improve care coordination. WHO and all United Nations agencies should collect data on all age groups to prevent the drafting of discriminatory policies. A lack of information on care outcomes limited the capacity of service providers to improve the quality of care, prevented policy-makers from effectively evaluating priorities and made it difficult for older people to select suitable care or support options. Dementia was both a social and medical issue and it was essential to promote dementia-friendly communities and an age-friendly approach. Ageing-related issues such as dementia had become part of the new global reality.

The representative of the WORLD DENTAL ASSOCIATION, speaking at the invitation of the CHAIRMAN, welcomed the draft global strategy and plan of action. Poor oral health led to impaired chewing, inadequate nutritional intake, deteriorating quality of life and even death. It could aggravate other conditions, including diabetes and dementia. A decline in oral function affected long-term health and placed pressure on public resources. The action plans implemented by Member States, WHO and international and national partners should include measures to promote oral health throughout life,

including action to address an increased need for oral health services for dentate older adults. In order to support healthy ageing policies, joint action should also include monitoring and reporting on oral health measures and related health factors, using standardized epidemiological surveillance and measures to foster scientific research on the link between noncommunicable diseases and oral diseases.

The representative of the INTERNATIONAL COUNCIL OF NURSES, speaking at the invitation of CHAIRMAN, said that the nursing profession was well placed to play an important role in promoting healthy ageing, given the varied roles that nurses played and their expertise. Many age-related problems were linked to chronic conditions and noncommunicable diseases. Mental health and disability were also key issues, and should be included in the action plan. A robust primary care system was instrumental in addressing health challenges related to an ageing population. Governments should remove regulatory barriers and support the work of nursing staff in managing chronic diseases, and in prevention work and care settings. It was important to ensure that adequate human resources were available in the form of qualified nursing staff. The International Council of Nurses looked forward to working with WHO and Member States to support the implementation of the global strategy and to ensure that a sufficient number of providers existed to meet the needs of an ageing population.

The representative of the INTERNATIONAL PHARMACEUTICAL FEDERATION, speaking at the invitation of the CHAIRMAN, said that pharmacists had a key role to play in the effective implementation of healthy ageing policies. The International Pharmaceutical Federation was committed to developing the role of pharmacists within health care teams, in order to meet the care needs of elderly persons. That goal could be achieved only through proper planning and development measures, using a competency-based approach. Through its training initiative, the Federation was investing in reforming the training offered to pharmacists, in order to ensure that there were sufficient numbers of trained professionals to respond to the current and future needs of an ageing population. In order to ensure the effective implementation of the WHO global strategy, it was necessary to base measures taken on evidence and best practices, some of which had been summarized in the *World report on ageing and health*, and to place emphasis on the added value provided by pharmacists through effective polymedication management, which could lead to substantial health care savings.

The representative of the WORLD MEDICAL ASSOCIATION, INC., speaking at the invitation of the CHAIRMAN, requested that the action plan should make reference to: developing guidelines for health settings that were accessible to older persons; training health professionals to care for an ageing population; developing policies to address the retention and retirement of health care professionals; conducting and presenting health promotion campaigns, especially those designed to support physical activity; developing policy on the oral health of older persons; adopting the recommendation issued by the World Health Professionals Alliance on collaborative practice; and encouraging health literacy as a key factor in fostering autonomy in older people. Given current demographic trends, the need for properly integrated primary health care services and nursing home facilities was likely to grow. The Association was committed to working with Governments to create a competent health workforce able to meet the needs of older patients.

The representative of the WORLD CONFEDERATION FOR PHYSICAL THERAPY, speaking at the invitation of the CHAIRMAN, said that closer collaboration between governments, nongovernmental organizations and professionals would help to build a seamless infrastructure through which health personnel could deliver targeted interventions of benefit to the population. As experts in movement, physical therapists had a role to play in all the objectives in the plan of action, including through contributing to health-related education, policy-making and practice. Ensuring that older persons remained physically active would make them more likely to continue contributing economically to society and less likely to require acute health services.

The representative of HELPAGE INTERNATIONAL, speaking at the invitation of the CHAIRMAN, said that the draft global strategy and plan of action provided a useful framework to consider the significant changes that would be required in the way health, care and other services were designed and delivered so as ensure that all people could live long and healthy lives. She particularly welcomed: the proposal for a decade focused on healthy ageing, and on moving towards an integrated, person-centred approach to health and care; the call for improved measurement, monitoring and research in order to fill data gaps on the health and well-being of older people; and the importance of older people's engagement.

The representative of HANDICAP INTERNATIONAL, speaking at the invitation of the CHAIRMAN, said that the draft strategy and plan of action was a positive first step towards achieving health for all, including older persons, as part of the 2030 Agenda for Sustainable Development. He supported the adoption and implementation of the documents under consideration.

The representative of the INTERNATIONAL PLANNED PARENTHOOD FEDERATION, speaking at the invitation of the CHAIRMAN, said that she welcomed the draft strategy and plan of action. Important elements of the documents included the acknowledgement that sexual health and rights were a key contributing factor to healthy ageing; the commitment to consider and include older people in measures to prevent and treat sexually transmitted infections; and the need to take into account the needs of older people from the lesbian, gay, bisexual, transgender and intersex community, those living with HIV and the poor and marginalized in terms of sexual health and rights when addressing healthy ageing. Her federation would continue implementing its own policies that supported the draft strategy and plan of action.

The representative of MEDICUS MUNDI INTERNATIONAL – INTERNATIONAL ORGANISATION FOR COOPERATION IN HEALTH CARE, speaking at the invitation of the CHAIRMAN, noted that the growing number of older persons in society could lead to higher levels of social exclusion. He criticized the fact that current universal health coverage models were based on insurance systems that discriminated against older people.

The DIRECTOR (Ageing and Life Course), responding to comments, said that the transition to older populations was one of the greatest demographic shifts the world had experienced. He noted the broad support expressed for the draft strategy and plan of action, which had been drafted with the Sustainable Development Goals in mind. The approach taken outlined actions to foster healthy and active ageing by building and maintaining the intrinsic capacity of individuals and creating more age-friendly environments. The comments made, including on the need for a greater focus on health promotion and to consider specific health issues and services, would be taken into account as implementation of the strategy began.

The draft resolution was approved.¹

The meeting rose at 20:55.

¹ Transmitted to the Health Assembly in the Committee's third report and adopted as resolution WHA69.3.

TENTH MEETING

Friday, 27 May 2016, at 10:20

Chairman: Mr M. BOWLES (Australia)

later: Ms T. KOIVISTO (Finland)

1. THIRD REPORT OF COMMITTEE A (document A69/72)

The RAPPORTEUR read out the draft third report of Committee A.

The report was adopted.¹

2. PROMOTING HEALTH THROUGH THE LIFE COURSE: Item 13 of the agenda (continued)

Health and the environment: draft road map for an enhanced global response to the adverse health effects of air pollution: Item 13.5 of the agenda (document A69/18)

The CHAIRMAN drew attention to a draft decision proposed by the delegations of Colombia, France, Germany, Monaco, Norway, Panama and Uruguay which read:

The Sixty-ninth World Health Assembly, having considered the report of the Secretariat on health and the environment: draft road map for an enhanced global response to the adverse health effects of air pollution,² decided:

(1) to endorse the road map for an enhanced global response to the adverse health effects of air pollution; and

(2) request the Director-General to report regularly on progress towards an enhanced global response to the adverse health effects of air pollution to the Health Assembly.

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

¹ See page 381.

² Document A69/18.

Decision: Health and the environment: draft road map for an enhanced global response to the adverse health effects of air pollution			
A. Link to the general programme of work and the programme budget			
1. Please indicate to which impact and outcome in the Twelfth General Programme of Work, 2014–2019 and which output in the Programme budget 2016–2017 this draft decision will contribute if adopted. Programme budget outcomes 2.1, 3.1 and 3.5 (outputs 3.5.1, 3.5.2 and 3.5.3.). General Programme of Work: decision is aligned with leadership priorities focused on addressing health-related development goals.			
2. If there is no link to the results as indicated in the Twelfth General Programme of Work, 2014–2019 and the Programme budget 2016–2017, please provide a justification for giving consideration to the draft decision. Not applicable.			
3. What is the proposed timeline for implementation of this decision? Work on air pollution and health will continue beyond 2019. A review will be undertaken in parallel with the development of the next general programme of work, which may result in some modifications to the overall budget depending on changes to broader Organizational priorities <i>If the timeline stretches to future programme budgets, please ensure that further information is provided in the costing section.</i>			
B. Budgetary implications of implementation of the decision			
1. Current biennium: estimated budgetary requirements, in US\$ million			
Level	Staff	Activities	Total
Country offices	0.68	1.26	1.94
Regional offices	2.99	5.87	8.86
Headquarters	2.33	1.94	4.27
Total	6.00	9.07	15.07
1(a) Is the estimated budget requirement in respect of implementation of the decision fully included within the current programme budget? (Yes/No) Yes, there could be possibility within the approved Programme budget 2016–2017 to ensure the implementation of this decision.			
1(b) Financing implications for the budget in the current biennium: – How much is financed in the current biennium? US\$ 3.5 million – What are the gaps? US\$ 11.6 million – What action is proposed to close these gaps? The gap will be addressed through coordinated resource mobilization efforts, including the financing dialogue, for possible financing by voluntary contributions.			

2. Next biennium: estimated budgetary requirements, in US\$ million			
Level	Staff	Activities	Total
Country offices	0.68	1.26	1.94
Regional offices	2.99	5.87	8.86
Headquarters	2.33	2.59	4.92
Total	6.00	9.72	15.72
2(a) Financing implications for the budget in the next biennium:			
– How much is currently financed in the next biennium?			
0			
– What are the financing gaps?			
US\$ 15.7 million			
– What action is proposed to close these gaps?			
The gap will be addressed through coordinated resource mobilization efforts, including the financing dialogue, for possible financing by voluntary contributions.			

A video presentation was given on the topic of cooperation between UNEP and WHO.

The representative of NORWAY said that the draft road map for an enhanced global response to the adverse health effects of air pollution provided for the scaling up of WHO capabilities at the central, regional and country levels by expanding the knowledge base, supporting monitoring and reporting and building global leadership and coordination. The Organization was strengthening its capacity to help Member States to combat the health effects of air pollution, including by accelerating its global monitoring of air pollution exposures and expanding advocacy on the associated health impacts. Of particular importance was the role of WHO with regard to the air pollution-related indicators introduced under the Sustainable Development Goal framework. Noting the need to build a global coalition of health, environment and climate actors to increase awareness and drive change, he said that the draft decision proposed by his Government and others affirmed the commitment of WHO to lead the global health response to air pollution.

The representative of MONACO said that the road map should be widely disseminated and implemented by Member States and for that reason her country had cosponsored the draft decision.

The representative of GERMANY said that she supported the statement by the representative of Norway and the draft road map.

The representative of the UNITED STATES OF AMERICA said that she welcomed efforts to address the health impacts of air pollution. However, the proposal to hold a global conference on air pollution and health to agree on further action was a cause of concern, since the required action had been set out in previous Health Assembly resolutions on the topic. She would be in favour of holding a meeting that focused on assessing progress and identifying remaining gaps in implementation activities. It was important to move from discussion to action.

The representative of FRANCE said that 2015 had been a significant year for action to combat air pollution and climate change with the adoption of the Sustainable Development Goals and the conclusion of the twenty-first session of the Conference of the Parties to the United Nations Framework Convention on Climate Change. He expressed support for the proposed draft decision and for the cross-sectoral approaches outlined in the road map with its monitoring and reporting

framework. The synergies between pollution and climate had been well illustrated in the video presentation by the Executive Director of UNEP. Public health sector participation in combating climate change would be examined at the Second Global Conference on Health and Climate to be hosted by the Government of France in July 2016.

The representative of PANAMA, speaking as a cosponsor of the draft decision, noted that there was scientific evidence to indicate that managing air quality and pollution posed a major challenge. Air pollution was a global issue which the international community must tackle together.

The representative of COLOMBIA expressed support for the statement by the representative of Norway.

The representative of INDIA took note of the draft road map, which included useful actions to prevent, contain and mitigate the impact of air pollution on health. His country was committed to taking appropriate action in that regard, under resolution WHA68.8 (2015) on health and the environment. The draft road map had been prepared by the Secretariat, without the involvement of Member States. It was not usual practice to endorse such a document. He requested that the draft decision should be amended accordingly.

The representative of the UNITED KINGDOM OF GREAT BRITAIN AND NORTHERN IRELAND welcomed the draft road map, which would enable the health sector to support international, national and local initiatives to reduce the health impacts of air pollution. The normative and advocacy work of WHO on air pollution and health was appreciated. He welcomed the progress made since the adoption of resolution WHA68.8 (2015). In response to the concern expressed by the representative of India, he suggested that, in the first paragraph of the draft decision, the word “endorse” should be replaced by “welcome”.

The representative of MONGOLIA also welcomed the draft road map. Although the capital of her country was one of the world’s most polluted cities, air quality remained an underfunded area of public health. An expert consultation carried out by her country and the UNICEF Mongolia country office had highlighted the importance of enhancing capacity in environmental control, including early warning and response systems, environmental health impact assessments and investment in environmentally-friendly technology. She supported the endorsement of the draft road map.

The representative of SWITZERLAND welcomed the draft road map and supported the link established therein with the Paris Agreement on climate change and the 2030 Agenda for Sustainable Development. Synergy was essential to implementation of resolution WHA68.8 (2015) and would increase the effectiveness of measures taken to combat air pollution. Similarly, policies to combat climate change and air pollution would contribute to the achievement of other health goals, in particular those related to noncommunicable diseases. Her country wished to be added to the list of sponsors of the draft decision.

The representative of SOUTH AFRICA welcomed the report by the Secretariat and commended the theory of change summarized in Annex 2 to the report. She endorsed the draft road map.

The representative of PARAGUAY acknowledged the importance of the report by the Secretariat and of work on the adverse health effects of air pollution in all sectors, including public health. She supported the draft road map, but noted that Member States would need technical and financial support to implement it.

The representative of SLOVENIA said that the 2030 Agenda for Sustainable Development included the issues of environmental protection, biodiversity, sustainable agriculture and food security.

Noting the alarming decline in the bee population, she wished to raise global awareness of the importance of the role of bees in food production as pollinators. Bees were an important indicator of a healthy environment and action to preserve the environment for bees would benefit humankind. In 2015, Slovenia had proposed that the United Nations should declare 20 May “World Bee Day” and it was expected that the first such day would be marked in 2018. She invited Member States and the Secretariat to support that initiative, since the conservation of bees was important to human life and health.

The representative of CHILE, expressing support for the draft road map, said that her country would work together with WHO and other relevant agencies to ensure its implementation. In that respect, she said that financial and technical assistance would be required in order to implement the draft road map in her country.

The representative of BARBADOS said that many air pollutants were by-products of human activity and noted the impact of inefficient combustion of cooking and vehicle fuels and of seasonal Saharan dust, which affected his country. The green economy required a comprehensive approach on the part of Government and society. Small island States like his, however, had limited resources for economic and social development and to address health issues. He supported the draft road map.

The representative of IRAQ said that measures to deal with air pollution should take into account the impact of pollution on workers’ health, the role of educational health services, and school and university curricula. The implementation of the road map would require potential legislative amendments, intersectoral collaboration and health promotion activities.

The representative of VIET NAM said that her Government was aware of the many environmental health challenges experienced in developing countries as a result of fast industrialization and urbanization. While supporting the draft road map, she requested that a reference to strengthening information sharing should be reflected in Figure 2 of Annex 1 on monitoring and reporting, given that data exchange on air pollutants and air quality would inform activity planning in that area. The time frame for the achievement of outcomes could also be extended beyond 2019, in order to allow time to mobilize resources and intersectoral engagement. It would be necessary to secure the resources and financial support required to implement the draft decision.

The representative of AUSTRIA said that intersectoral cooperation was essential to strengthen global data on air pollution. Given its mandate to promote sustainable development and its history of technical cooperation in initiatives to reduce air pollution, UNIDO must be involved in efforts to improve databases.

The representative of COSTA RICA said that countries’ particular health contexts should form the basis of national policies and actions, and the links between climate change and ambient air pollution should be explored in formulating them. The synergistic and cumulative effects of pollutants should be incorporated in health indicators in order to develop robust air quality indexes. The support of regional and international organizations was essential to strengthen health and environment institutions, and to foster close cooperation between epidemiological monitoring and environmental agencies. The report should incorporate Member States’ observations.

The representative of NEPAL, speaking on behalf of the Member States of the South-East Asia Region, underlined the need for specific strategies to counter household and ambient air pollution. Household air pollution affected predominantly low-income households and had an impact on gender equality and development. Since over 60% of households in his Region depended on solid fuels for energy, the road map should focus on strengthening the role of the health sector in addressing household air pollution as well as on resource mobilization should be mobilization. Refined

monitoring tools were also needed in rural areas. He proposed that paragraph (2) of the draft decision should be amended to read: “request the Director-General to report the progress towards an enhanced global response to the adverse health effects of air pollution to the Seventy-first World Health Assembly and the achievement to the Seventy-third World Health Assembly”.

The representative of THAILAND said that the road map served to enhance health sector leadership at all levels, particularly at the community level. Leadership in the area of surveillance was especially important. Successful implementation of the road map required collaborative policy-making. However, the design and application of policies to address air pollution remained a challenge in many countries owing to a lack of knowledge.

The representative of SAUDI ARABIA highlighted the importance of sound management in the development of measures to combat the adverse health effects of air pollution and of incorporating lessons learned from all sectors. More effective multisectoral cooperation was required in order to integrate health in all policies and develop actions relating to health and sustainable development. Additional resources were also necessary to design comprehensive air pollution reduction strategies.

The representative of MEXICO said that his Government had taken various measures to address the adverse health effects of air pollution. The road map should include more specific technical information regarding pollutants and air quality assessment criteria. It should also cover diseases related to oxidative stress and their additional negative repercussions, such as school and work absenteeism. The implementation of the road map required the participation of the environment and energy sectors, and civil society. Prevention strategies using early warning systems based on continuous epidemiological monitoring of the impact on health of air pollution should also be incorporated into the road map.

The representative of BRAZIL highlighted the need to include rural populations at risk of exposure to pesticides in policies and measures on public health and air quality control. Her Government had launched a national plan on air pollution. She expressed the hope that the road map would facilitate the establishment of health information networks to fill knowledge gaps in the health sector and increase technical support for other relevant sectors.

The representative of CANADA noted that increased awareness of the adverse health effects of air pollution would guide governmental and public actions to improve air quality and health. She commended WHO leadership regarding technical policy-making and best practices in that area. Her Government looked forward to contributing to the proposed road map in the light of knowledge gained from monitoring and reporting air pollutant levels and quantifying health benefits from improved air quality in Canada.

The representative of INDONESIA said that her Government participated in programmes to reduce household air pollution, such as the Clean Stove Initiative Indonesia, with a view to decreasing the rate of child pneumonia. Successful air pollution control required effective public policies and business models, and their swift implementation at national levels. She underscored the importance of providing guidance to expand knowledge bases, improve monitoring mechanisms and strengthen institutional capacity.

The representative of SRI LANKA expressed concern at the annual death rate as a result of diseases caused by air pollution. Given that many low-income households depended on solid fuels for cooking, it was vital to introduce low-cost energy alternatives into households. Her Government appreciated WHO's commitment to respond to the adverse health effects of air pollution and appealed to the global community to support the Organization through a multisectoral approach.

The representative of CHINA expressed the hope that WHO would enhance cooperation with relevant environmental agencies for the effective promotion of national coordination mechanisms. She proposed that relevant core monitoring indicators should be developed with an eye to regularly updating the road map.

The representative of the UNITED REPUBLIC OF TANZANIA said that his Government had taken various multisectoral initiatives to address the issue of air pollution. Challenges to the implementation of measures to reduce air pollution included growing urbanization and poor urban planning, lack of data, limited institutional and technical capacity, and poor public awareness. He supported the draft decision.

The representative of TOGO described measures adopted in Togo to reduce ambient air pollution by, inter alia, promoting other sources of energy and regulating air pollutants. Despite concerted efforts, many challenges remained, particularly in raising the awareness of stakeholders and designing targeted policies. He supported the draft decision.

The representative of MALAYSIA expressed appreciation for WHO's commitment to tackling air pollution. The road map addressed the challenges common to many countries. The proposed monitoring and reporting framework would serve as a guide and assist Member States in giving effect to the road map. The complexity of the issue required inter-agency cooperation and the participation of all stakeholders.

The representative of ECUADOR, drawing attention to the important synergies and linkages between the 2030 Agenda for Sustainable Development and the draft road map, particularly regarding the health impact of urban air pollution in large cities, said that it should be part of the new global urban agenda. He sought clarification on the time frame for achieving the outcomes of the draft road map: he had understood that the deadline was 2020, but one of the measures had a deadline of 2030. He supported the draft decision, but highlighted the need for financial support for developing countries such as Ecuador.

The representative of LIBERIA, speaking on behalf of the Member States of the African Region, said that statistics showed that annual deaths attributed to environmental pollution were significantly higher than deaths from serious illnesses, including HIV/AIDS, malaria and tuberculosis, and mostly affected in low- and middle-income countries. The African Region faced particular challenges in addressing air pollution and welcomed the draft road map as an opportunity to fast-track implementation of the Sustainable Development Goals. He therefore encouraged Member States to endorse the draft road map as a springboard for the development of national strategies and action plans to reduce household and ambient air pollution health risks and as a framework for setting policies for air pollution mitigation.

The representative of the RUSSIAN FEDERATION, supporting the draft road map, said that her Government had noted the conclusions clearly drawn in the Secretariat's report pointing to the link between climate change and air pollution, but did not consider the adverse effects of air pollution to be a major climate factor. Further research was needed along the lines of the United Nations' work under the United Nations Framework Convention on Climate Change on the added value of linking short-lived climate pollutants and climate change and the adverse effects of air pollution.

The representative of NIGER said that, as a signatory to the Libreville Declaration on Health and Environment in Africa in 2008, his Government had drawn up an action plan to implement the commitments of the Declaration, which included the establishment of a health-and-environment strategic alliance as the basis for joint action. It therefore endorsed the draft decision.

The representative of TIMOR-LESTE said that forest fires and the heavy use of solid fuel as a primary energy source were the major causes of air pollution in Timor-Leste, and the Government had adopted a range of measures to address the problem. It fully endorsed the draft road map.

The representative of the PHILIPPINES said that her Government welcomed all four categories of the draft road map. Since monitoring and reporting was one of those categories, it encouraged WHO to report regularly on the progress of its implementation to Member States. It therefore endorsed the draft road map.

The representative of TUNISIA endorsed the draft road map and urged WHO to disseminate it widely and Member States to implement it. She outlined action taken by her Government to combat the adverse effects of air pollution on health and requested WHO support for its efforts to implement integrated and intersectoral strategies, as set out in the draft road map.

The representative of MOROCCO said that, given the extent of the problems caused by poor air quality and climate change, her Government supported WHO efforts to prevent air pollution and welcomed the draft road map. It sought the support of WHO and other international organizations in building the country's public health technical capacity to enable it to determine true levels of public exposure to air pollutants and to set up effective monitoring and surveillance systems.

The representative of the DOMINICAN REPUBLIC endorsed the draft road map, but highlighted the need for technical and financial assistance to be provided to countries who struggled to implement their national legislation and regulations on pollution. Developed countries – which caused the most global pollution – had a responsibility to ensure that transnational corporations adhered to the legislation and regulations of developed countries when operating in other countries.

The representative of UNEP said that the draft road map set the course for joint efforts across United Nations agencies and national and local governments to remove inefficient technologies and change policies that led to dangerous air pollution. Since 2012, there had been an international effort hosted by UNEP through the Climate and Clean Air Coalition, which was working to reduce emissions of short-lived climate pollutants that had a relatively short lifespan in the atmosphere and a warming influence on climate, with a detrimental impact on health and agricultural crop production. WHO was a crucial partner in the Coalition – leading its Urban Health Initiative and global awareness-raising Breathe Life Campaign – which was currently developing a pilot approach to engaging at the city level in Accra, Ghana – a model to be scaled up for implementation in cities across Africa, Asia and Latin America. UNEP looked forward to working with WHO to reverse the growing trend in air pollution emissions and to reducing near-term global warming.

The observer of CHINESE TAIPEI welcomed and endorsed the draft road map and outlined action taken to reduce environmental hazards. She emphasized the need for health professionals to lead the way; they should be the first and strongest to advocate, enable and mediate actions against environmental hazards and should practise what they preached.

The representative of the WORLD MEDICAL ASSOCIATION, INC., speaking at the invitation of the CHAIRMAN, said that he was deeply concerned by the health and environmental impacts of air pollution. As specific and targeted strategies to address air pollution were required, his association was in favour of raising the profile of the problem and committed to providing technical expertise where required. It was crucial to address the impact of air pollution on vulnerable populations. The association was also in favour of engaging with existing post-2015 development processes. He urged the Secretariat and Member States to promote the effective engagement of the health sector in other forums, such as those relating to the United Nations Framework Convention on

Climate Change. Referring to the Paris Agreement, he called on governments to address climate change in the light of their human rights obligations, including the right to health for all.

The representative of the INTERNATIONAL UNION AGAINST TUBERCULOSIS AND LUNG DISEASE, speaking at the invitation of the CHAIRMAN, noted the link between noncommunicable diseases and air pollution and stood ready to support implementation of the draft road map. To further strengthen the draft road map, WHO and Member States could: identify effective policy interventions based on criteria beyond the reduction of air pollution, including fully incorporating the public health advantages of solutions that simultaneously reduced exposure to air pollution and other noncommunicable disease risk factors; establish a comprehensive indicator framework, to be developed ahead of the Seventieth World Health Assembly, aligned with the commitments of the Paris Agreement and 2030 Agenda for Sustainable Development; and promote a multisectoral and intersectoral approach throughout implementation of the draft road map, which should recognize the role of civil society.

The representative of the WORLD COUNCIL OF CHURCHES, speaking at the invitation of the CHAIRMAN, welcomed the draft road map, but expressed concern at its portrayal of the new Paris Agreement as a panacea for the adverse effects of climate change, since the Agreement did not go beyond the legal framework of the United Nations Framework Convention on Climate Change adopted more than 20 years previously. The Paris Agreement did not contain an obligation for individual States to ensure adequate mitigation and it provided no concrete guarantee of sufficient finance, capacity-building or access to the technology that States required to protect their people. Moreover, the significant impact of climate change on air pollution was insufficiently considered in the draft road map. The workplan on health and climate change posted on the WHO website appeared to have been conceived without consultation with important partners and was weak substantively, especially in relation to the concerns of developing countries.

The ASSISTANT DIRECTOR-GENERAL (Family, Women's and Children's Health) said that it was clear from the discussion that there was understanding that air pollution was a leading cause of avoidable deaths and of diseases, including noncommunicable diseases. There was also a clear sense of urgency and of the need for intersectoral action. WHO would use the proposed global conference on air pollution and health to track progress on implementation activities. The Secretariat would work with Member States in seeking ways to further sharpen the indicators of the monitoring framework linked to the draft road map and to identify better ways to capture information and data that would enable them to develop effective policies. She welcomed the suggestion with respect to further collaboration on strengthening information and data monitoring. She agreed on the importance of strengthening collaboration with the WHO partners within the United Nations system that were responsible for other sectoral actions such as UNEP, the Secretariat of the United Nations Framework Convention on Climate Change and WMO, and of implementing intersectoral actions. With regard to the many requests for technical and financial support and action at the country level to help Member States implement the ambitious draft road map, the Secretariat was looking to enhance that area of work in the programme budget for 2018–2019.

At the invitation of the CHAIRMAN, the SECRETARY read out the proposed amendments to the draft decision: paragraph (1) would read: "to welcome the road map for an enhanced global response to the adverse health effects of air pollution"; and paragraph (2) would read: "request the Director-General to report the progress towards an enhanced global response to the adverse health effects of air pollution to the Seventy-first World Health Assembly and its achievement to the Seventy-third World Health Assembly".

The draft decision, as amended, was approved.¹

Role of the health sector in the sound management of chemicals: Item 13.6 of the agenda (document A69/19)

The CHAIRMAN drew attention to a draft resolution proposed by the delegations of Argentina, Canada, Monaco, Panama, Thailand, the United States of America, Uruguay, and the Member States of the European Union, which read:

The Sixty-ninth World Health Assembly,

(PP1) Having considered the report on the role of the health sector in the sound management of chemicals;²

(PP2) Recalling resolution WHA59.15 (2006), in which the Health Assembly welcomed the Strategic Approach to International Chemicals Management adopted by the International Conference on Chemicals Management (Dubai, United Arab Emirates, 4–6 February 2006) with its overall objective to achieve “the sound management of chemicals throughout their life cycle so that, by 2020, chemicals are used and produced in ways that lead to the minimization of significant adverse effects on human health and the environment,” as inspired by paragraph 23 of the Johannesburg Plan of Implementation of the World Summit on Sustainable Development (Johannesburg, South Africa, 26 August–4 September 2002);

(PP3) Reaffirming its commitment to the outcome document of the Rio+20 Conference “The future we want”;

(PP4) Further recalling paragraph 213 of the outcome document “The future we want,” from the 2012 United Nations Conference on Sustainable Development which states “[w]e reaffirm our aim to achieve, by 2020, sound management of chemicals throughout their life cycle and of hazardous waste in ways that lead to minimization of significant adverse effects on human health and the environment, as set out in the Johannesburg Plan of Implementation”;

(PP5) Recalling also, paragraph 214 of “The future we want” which calls for “the effective implementation and strengthening of the Strategic Approach to International Chemicals Management as part of a robust, coherent, effective and efficient system for the sound management of chemicals throughout their life cycle”;

(PP6) Noting the limited time remaining to make progress toward the 2020 goal, and the urgent need for practical action and technical cooperation within the health sector, as well as with other sectors;

(PP7) Acknowledging that chemicals contribute significantly to the global economy, living standards and health but that unsound management of chemicals throughout their life cycle contributes significantly to the global burden of disease, and that much of this burden is borne by developing countries;

(PP8) Noting that annually 12.6 million deaths (22.7% of all deaths) and 596 million disability-adjusted life-years (21.8% of all disease burden in disability-adjusted life-years) are thought to be linked to modifiable environmental factors, including chemical exposures and that in 2012, 1.3 million deaths (2.3% of all deaths) and 43 million disability-adjusted life-years (1.6% of all disease burden in disability-adjusted life-years) were attributable to exposures to a number of selected chemicals.³ Among these, addressing lead exposure would prevent 9.8% of intellectual disability, 4% of ischaemic heart disease and 4.6% of stroke in the population and

¹ Transmitted to the Health Assembly in the Committee’s fourth report and adopted as decision WHA69(11).

² Document A69/19.

³ Prüss-Ustün A, et al. Preventing Disease through Healthy Environments: a global assessment of the environmental burden of disease. Geneva: World Health Organization; 2016 (http://www.who.int/quantifying_ehimpacts/publications/preventing-disease/en/, accessed 19 May 2016).

unintentional poisonings killed an estimated 193 000 people in 2012, 85% in developing countries where such poisonings are strongly associated with excessive exposure to, and inappropriate use of, toxic chemicals. Recognizing that due to the complex nature of the issue, disease burden information is only available for a very small number of chemical exposures and that people are exposed to many more chemicals in their daily lives;

(PP9) Concerned about acute, chronic and combined adverse effects that can result from exposure to chemicals and waste and that the risks are often unequally distributed and can be more significant for some vulnerable populations, especially women, children, and, through them, future generations;

(PP10) Underlining the need to address the social, economic, and environmental determinants of health to improve health outcomes and achieve sustainable development;

(PP11) Underscoring the importance of protecting health and reducing health inequities, including by the reduction of adverse health impacts from chemicals and waste, by adopting health-in-all policies and whole-of-government approaches, as appropriate;

(PP12) Recalling WHO's longstanding recognition of the importance of sound chemicals management for human health, the key role of WHO in providing leadership on the human health aspects of the sound management of chemicals throughout their life cycle, and the necessity of health sector participation in and contribution to these efforts as set out in resolution WHA59.15 (2006) on the Strategic Approach to International Chemicals Management; resolution WHA63.25 (2010) on improvement of health through safe and environmentally sound waste management; resolution WHA63.26 on improvement of health through sound management of obsolete pesticides and other obsolete chemicals; resolution WHA67.11 (2014) on public health impacts of exposure to mercury and mercury compounds; and resolution WHA68.8 (2015) on health and the environment: addressing the health impact of air pollution;

(PP13) Recalling further the health-related outcomes of the second, third and fourth sessions of the International Conference on Chemicals Management, which drew attention to the need for greater involvement of the health sector and resulted in the adoption of a Strategy for strengthening engagement of the health sector in the implementation of the Strategic Approach¹ which details the key roles and responsibilities of the health sector in sound chemicals management;

(PP14) Recalling also paragraph 1 of International Conference on Chemicals Management resolution IV/1 adopted by the fourth session of the International Conference on Chemicals Management which endorsed the overall orientation and guidance for achieving the 2020 goal as a voluntary tool that will assist in the prioritization of efforts for the sound management of chemicals and waste as a contribution to the overall implementation of the Strategic Approach, and mindful of the invitation in paragraph 5 to "the organizations of the Inter-Organization Programme for the Sound Management of Chemicals and of the United Nations Environment Management Group that have not already done so to issue, where possible by 1 July 2016, a declaration signalling their commitment to promote the importance of the sound management of chemicals and waste both within and outside their organizations, including the actions planned within their own mandates to meet the 2020 goal";

(PP15) Acknowledging with appreciation WHO's extensive activities in this regard including, but not limited to, supporting countries to implement the International Health Regulations (2005) in relation to chemical incidents, the establishment in 2013 of the WHO Chemical Risk Assessment Network, participation in the development of the Inter-Organization Programme for the Sound Management of Chemicals (IOMC) Toolbox for Decision Making in Chemicals Management, joint leadership of the Global Alliance to Eliminate Lead Paint, and engagement with relevant chemicals and waste-related multilateral environmental agreements;

¹ See document SAICM/ICCM.3/20 for the strategy and document SAICM/ICCM.3/24, Annex 1 for resolution III/4.

(PP16) Also acknowledging initiatives undertaken at the national and regional levels, and through other bodies of the United Nations system and other relevant stakeholders, and the important contribution that these initiatives make to protecting health from hazardous chemicals and waste;

(PP17) Recalling the relevant chemicals- and waste-related multilateral agreements including, inter alia, the Stockholm Convention on Persistent Organic Pollutants (2004), the Rotterdam Convention on the Prior Informed Consent Procedure for Certain Hazardous Chemicals and Pesticides in International Trade (2004, revised 2008), the Basel Convention on the Control of the Transboundary Movements of Hazardous Wastes and their Disposal (1989) and the Minamata Convention on Mercury (2013);

(PP18) Concerned that, despite these efforts, more progress has to be made towards minimizing the significant adverse effects on human health that may be associated with chemicals and waste, and recognizing that there is an urgent need to address existing gaps between the capacities of different countries;

(PP19) Recognizing the need for enhanced cooperation aimed at strengthening the capacities of developing countries for the sound management of chemicals and hazardous wastes and promoting adequate transfer of cleaner and safer technology to those countries;

(PP20) Emphasizing the importance of bringing into force the Minamata Convention on Mercury as soon as possible;

(PP21) Welcoming the outcome of WHO's survey of the priorities of the health sector towards achievement of the 2020 goal of sound chemicals management,¹ which builds on the Strategy for strengthening the engagement of the health sector in the implementation of the Strategic Approach;

(PP22) Recognizing paragraph 1 of the Dubai Declaration on International Chemicals Management (2006), which states that "the sound management of chemicals is essential if we are to achieve sustainable development, including the eradication of poverty and disease, the improvement of human health and the environment, and the elevation and maintenance of the standard of living in countries at all levels of development";

(PP23) Welcoming the 2030 Agenda for Sustainable Development, in particular Sustainable Development Goal target 3.9 to substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination by 2030, and further recognizing Goal target 12.4 to achieve, by 2020, the environmentally sound management of chemicals and all wastes throughout their life cycle, in accordance with agreed international frameworks, as well as other goals and targets relevant to health aspects of chemicals and waste management, such as Goal target 6.3 on the improvement of water quality;

(PP24) Convinced that the achievement of sound management of chemicals and waste throughout their life cycle requires a multisectoral approach within which the health sector has a critical role in achieving the 2020 goal and in setting priorities for chemicals and waste for the post-2020 period;

(PP25) Stressing the responsibility of industry to make available to stakeholders such data and information on health and environmental effects of chemicals as are needed safely to use chemicals and the products made from them;

(PP26) Welcoming the integrated approach to financing the sound management of chemicals and wastes developed by UNEP,² which is applicable to the Strategic Approach and underscores that the three components of an integrated approach, namely mainstreaming, industry involvement and dedicated external financing, are mutually reinforcing and are all important for the financing of the sound management of chemicals and waste at all levels;

¹ Document SAICM/ICCM.4/INF/11.

² Sound management of chemicals: UNEP's contribution to the achievement of the 2020 goal (<http://www.unep.org/chemicalsandwaste/Portals/9/Mainstreaming/Sound%20Management%20of%20Chemicals/SoundManagementofChemicals.pdf>, accessed 19 May 2016).

(PP27) Aware that strengthening of health systems and appropriately trained health work force is a key factor for facilitating the health sector to more effectively contribute to the sound management of chemicals and waste;

(PP28) Aware of the need to strengthen the role of the health sector so as to ensure its contribution to multisectoral efforts to meet the 2020 goal and beyond, and that this would be facilitated by the development of a road map outlining concrete actions for the health sector,

(OP) 1. URGES Member States:¹

- (1) to engage proactively, including by strengthening the role of the health sector, in actions to soundly manage chemicals and waste at the national, regional and international levels in order to minimize the risk of adverse health impacts of chemicals throughout their life cycle;
- (2) to develop and strengthen, as appropriate, multisectoral cooperation at the national, regional and international levels in order to minimize and prevent significant adverse impacts of chemicals and waste on health, including within the health sector itself;
- (3) to take account of the Strategic Approach's overall orientation and guidance toward the 2020 goal, including the health sector priorities, as well as the Strategy for strengthening engagement of the health sector, and consider Emerging Policy Issues and Other Issues of Concern,² and to take immediate action where possible and where appropriate to accelerate progress toward the 2020 goal;
- (4) to encourage all relevant stakeholders of the health sector to participate in the Strategic Approach and to ensure appropriate linkages with their national and regional Strategic Approach focal points, and to participate in the reports on progress for the Strategic Approach;
- (5) to strengthen individual, institutional and networking capacities at the national and regional levels to ensure successful implementation of the Strategic Approach;
- (6) to encourage health sector participation in the intersessional process established through the fourth session of the International Conference on Chemicals Management to prepare recommendations regarding the Strategic Approach and the sound management of chemicals and waste beyond 2020, including in the third meeting of the Open Ended Working Group;
- (7) to continue and, where feasible, increase support, including financial or in-kind scientific and logistical support to the WHO Secretariat's regional and global efforts on chemicals safety and waste management, as appropriate;
- (8) to pursue additional initiatives aimed at mobilizing national and, as appropriate, international resources, including for the health sector, for the sound management of chemicals and waste;
- (9) to strengthen international cooperation to address health impacts of chemicals and waste, including through facilitating transfer of expertise, technologies and scientific data to implement the Strategic Approach, as well as exchanging good practices;

¹ And, where applicable, regional economic integration organizations.

² **Emerging policy Issues:** lead in paint, chemicals in products, hazardous substances within the life cycle of electrical and electronic products, nanotechnologies and manufactured nanomaterials, endocrine-disrupting chemicals, and environmentally persistent pharmaceutical pollutants; **Other issues of concern:** Perfluorinated chemicals and the transition to safer alternatives, and highly hazardous pesticides (http://www.saicm.org/index.php?option=com_content&view=article&id=452&Itemid=685, accessed 20 May 2016).

(OP) 2. REQUESTS the Director-General:

- (1) to develop, in consultation with Member States,¹ bodies of the United Nations system, and other relevant stakeholders, a road map for the health sector at the national, regional and international level towards achieving the 2020 goal and contributing to relevant targets of the 2030 Agenda for Sustainable Development, taking into account the overall orientation and guidance of SAICM, and the intersessional process to prepare recommendations regarding the Strategic Approach and the sound management of chemicals and waste beyond 2020 established through the fourth session of the International Conference on Chemicals Management, and building on WHO's existing relevant work, as well as the SAICM Health Sector Strategy, and with particular emphasis on the following areas:
 - (a) health sector participation in and support for the establishment and strengthening of relevant national legislative and regulatory frameworks;
 - (b) supporting the establishment or strengthening of national, regional or international coordinating mechanisms, as appropriate for multisectoral cooperation, and in particular enhancing engagement of all relevant health sector stakeholders;
 - (c) strengthening communication and access to relevant, understandable and up-to-date information to increase interest in and awareness of the importance to health of the sound management of chemicals and waste, particularly for vulnerable populations, especially women, children, and through them, future generations;
 - (d) participating in bilateral, regional or international efforts to share knowledge and best practices for the sound management of chemicals, including the WHO Chemicals Risk Assessment Network;
 - (e) participating actively in ongoing work on the Strategic Approach's Emerging Policy Issues and Other Issues of Concern, as well as the intersessional process established through the fourth session of the International Conference on Chemicals Management to prepare recommendations regarding the strategic approach and the sound management of chemicals and waste beyond 2020;
 - (f) encouraging implementation of the Strategic Approach's Strategy for strengthening engagement of the health sector in the implementation of the Strategic Approach, including the review of the health sector's own role to the extent that it is a user of chemicals and a producer of hazardous waste;
 - (g) mainstreaming of gender as a component in all policies, strategies and plans for the sound management of chemicals and waste, considering gender differences in exposure to and health effects of toxic chemicals, while ensuring participation of women as agents of change in policy and decision making; and
 - (h) strengthening of efforts on implementation of the updated health sector priorities;
- (2) to build on and enhance implementation of actions pursuant to resolution WHA63.25 on improvement of health through safe and environmentally sound waste management, and to develop a report on the impacts of waste on health, the current work of the WHO in this area, and possible further actions that the health sector, including WHO, could take to protect health;

¹And, where applicable, regional economic integration organizations.

- (3) to continue to exercise and enhance the leading role of WHO in the Strategic Approach to foster the sound management of chemicals throughout their life cycle with the objective of minimizing and, where possible, preventing significant adverse effects on health;
- (4) to support strengthening the capacities at all levels for the production, availability and analysis of quality, accessible, timely, reliable and appropriately disaggregated data for the adequate measurement of progress towards Target 3.9 of the 2030 Agenda for Sustainable Development and to improve, where appropriate, evidence-based data;
- (5) to continue current efforts to engage the health sector in chemicals management and make progress in chemical safety in particular in the implementation of the International Health Regulations (2005);
- (6) to support Member States by providing technical support, including at the regional and country levels, for strengthening the role of the health sector towards meeting the 2020 goal, including by enhancing capacities at individual, institutional and networking levels and by dissemination of evidence-based best practices;
- (7) to support Member States to strengthen coordination for the health sector in responding to existing international efforts and, in so doing, avoid duplication;
- (8) to set aside adequate resources and personnel for the work of the Secretariat, in line with the Programme budget 2016–2017 and the Twelfth General Programme of Work, 2014–2019 and taking into account the recent call at the fourth session of the International Conference on Chemicals Management and the invitation conveyed at the first session of the United Nations Environment Assembly on support for the Strategic Approach; and to work in collaboration with the secretariat of the Strategic Approach to find means to increase that secretariat's capacity to support activities related to the health sector;
- (9) to present to the Seventieth World Health Assembly:
 - (a) a road map outlining concrete actions to enhance health sector engagement towards meeting the 2020 goal and contributing to relevant targets of the 2030 Agenda for Sustainable Development, as requested in operative subparagraph 2(1) above; and
 - (b) a progress report on the preparation of the report requested in operative subparagraph 2(2) above;
- (10) to update the road map according to the outcome of the intersessional process to prepare recommendations regarding the Strategic Approach and the sound management of chemicals and waste beyond 2020.

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

Resolution: The role of the health sector in the Strategic Approach to International Chemicals Management towards the 2020 goal and beyond			
A. Link to the general programme of work and the programme budget			
<p>1. Please indicate to which impact and outcome in the Twelfth General Programme of Work, 2014–2019 and which output in the Programme budget 2016–2017 this draft resolution will contribute if adopted.</p> <p>Twelfth General Programme of Work, 2014–2019: Impact goals: Reduce premature mortality from noncommunicable diseases; and Prevention of death, illness and disability arising from emergencies; and Outcome: Reduced environmental threats to health.</p> <p>Programme budget 2016–2017: Output 3.5.1 Countries enabled to assess health risks and develop and implement policies, strategies or regulations for the prevention, mitigation and management of the health impacts of environmental and occupational risks;</p> <p>Output 3.5.2 Norms and standards established and guidelines developed for environmental and occupational health risks and benefits associated with, for example, air and noise pollution, chemicals, waste, water and sanitation, radiation, nanotechnologies and climate change; and</p> <p>Output 3.5.3 Public health objectives addressed in implementation of multilateral agreements and conventions on the environment and in relation to the proposed sustainable development goals and the post-2015 development agenda.</p>			
<p>2. If there is no link to the results as indicated in the Twelfth General Programme of Work, 2014–2019 and the Programme budget 2016–2017, please provide a justification for giving consideration to the draft resolution.</p> <p>Not applicable.</p>			
<p>3. What is the proposed timeline for implementation of this resolution?</p> <p>A road map, to be developed in consultation with Member States and others, will be presented to the Seventieth World Health Assembly, in 2017, and a report on waste produced within the current biennium.</p> <p><i>If the timeline stretches to future programme budgets, please ensure that further information is provided in the costing section.</i></p>			
<p>B. Budgetary implications of implementation of the resolution</p> <p>The budgetary implications are largely driven by the process used for consultation on the road map.</p>			
1. Current biennium: estimated budgetary requirements, in US\$ million			
Level	Staff	Activities	Total
Country offices	n/a	n/a	n/a
Regional offices	0.18	0.60	0.78
Headquarters	0.12	0.26	0.38
Total	0.30	0.86	1.16
<p>1(a) Is the estimated budget requirement in respect of implementation of the resolution fully included within the current programme budget? (Yes/No)</p> <p>Yes.</p>			

1(b) Financing implications for the budget in the current biennium:			
– How much is financed in the current biennium?			
US\$ 0.35 million			
– What are the gaps?			
US\$ 0.81 million			
– What action is proposed to close these gaps?			
The gap will be addressed through coordinated resource mobilization efforts for possible financing by voluntary contribution.			
2. Next biennium: estimated budgetary requirements, in US\$ million			
Level	Staff	Activities	Total
Country offices	n/a	n/a	n/a
Regional offices	n/a	n/a	n/a
Headquarters	n/a	n/a	n/a
Total	n/a	n/a	n/a
2(a) Financing implications for the budget in the next biennium:			
– How much is currently financed in the next biennium?			
Not applicable.			
– What are the financing gaps?			
Not applicable.			
– What action is proposed to close these gaps?			
Not applicable.			

The representative of CANADA, speaking on behalf of the Member States of the Region of the Americas, said that while the production and use of chemicals continued to grow, information on the disease burden was available for only a small number of chemical exposures despite the fact that people were exposed to an increasing number of chemicals in their daily lives and even before birth. The negative impact of the unsound management of chemicals and waste on health systems was therefore greater than estimated. The health sector had a crucial role to play in identifying risks and implementing effective interventions in order to achieve the 2020 goal of the Strategic Approach to International Chemicals Management and the related Sustainable Development Goals. The active engagement of the health sector would contribute to: preventing ill-health and diseases linked to chemical exposures; raising awareness; elaborating methods for chemical risk assessment; filling gaps in scientific knowledge to support evidence-based policies; and coordinating joint activities through a Health in All Policies approach. Particular attention should be given to populations that were more vulnerable to chemicals and waste exposure. WHO had a key role to play in supporting health sector participation and should play an active role international forums. The Member States of the Region supported the adoption of the draft resolution. All regions were invited to consider the road map outlining concrete actions to enhance health sector engagement towards meeting the 2020 goal and contributing to the relevant targets of the 2030 Agenda for Sustainable Development during their regional committee meetings in 2016.

Speaking on behalf of Canada, she said that her country would contribute a resource to develop the road map and assist in other chemical-related activities; she invited Member States to make similar contributions to further WHO's work.

The representative of IRAQ said that it was important to use environmentally-friendly chemicals; store chemicals safely; and monitor and assess their use and impact. WHO could offer valuable support in the training of people working with chemicals. The health, environment and other sectors must promote safe and efficient ways of handling chemicals, incorporating primary health care concepts.

The representative of SURINAME drew attention to the specific needs of small, developing countries with limited human and financial resources for the sound management of chemicals. Comparable countries and institutions in a region should share information and resources to improve their ability to access, interpret, apply and adapt scientific knowledge to their local context.

The representative of PANAMA supported the draft resolution. Health ministries should guide global and regional work on chemicals and spur countries' actions with intersectoral and interagency support. A cost analysis – including data on poisonings and chemical exposures at the global, regional and national levels – should be carried out to determine how much it would cost the health sector if no actions were taken. WHO should conduct more research on endocrine disrupting chemicals and build countries' capacities in that area.

The representative of the PHILIPPINES supported implementation of the priority actions outlined in the draft road map. Member States must identify exposure assessment methodologies that could apply to a number of countries. She encouraged WHO, UNEP and other international organizations and programmes to facilitate an integrated financial approach to support the initiatives of the Strategic Approach. She expressed support for the draft resolution.

The representative of the NETHERLANDS, speaking on behalf of the European Union and its Member States, said that Turkey, the former Yugoslav Republic of Macedonia, Serbia, Albania, Bosnia and Herzegovina, Ukraine, the Republic of Moldova and Georgia aligned themselves with his statement. The draft resolution underlined the need to strengthen the role of WHO in implementing the 2020 goal of the Strategic Approach. He trusted that WHO's road map for the health sector would be coordinated with the overall orientation and guidance for achieving the 2020 goal. Multisectoral and multistakeholder engagement were important. The Member States of the European Union were cosponsors of the draft resolution and were committed to its full implementation.

The representative of GERMANY strongly encouraged the adoption of the draft resolution. Her Government was committed to its full implementation. She appreciated the initiative to develop a road map. WHO's commitment to the Strategic Approach in its areas of expertise with adequate resources and personnel was commendable.

The representative of BRAZIL highlighted the importance of close cooperation between the health sector and other sectors. WHO's technical support to countries in need was vital to strengthening institutional capacity, improving regulatory frameworks and training health workers. She welcomed the draft resolution and said that her Government was committed to further discussions on chemicals.

The representative of SENEGAL said that sound management of chemicals had been incorporated into the Emerging Senegal Plan. WHO should increase its support for the creation and strengthening of poison centres.

The representative of MAURITANIA highlighted a number of public health concerns in Africa, including the continued use of chemicals with adverse impacts on human health and the environment, particularly pesticides, and the illegal dumping of waste and recyclable materials. While progress had

been made in the sound management of chemicals in the African Region, weak technical and institutional capacities were still a major obstacle.

The representative of the RUSSIAN FEDERATION said that chemical security was a priority in his country. International cooperation on the sound management of chemicals should take into account the need to promote the human rights to life and health, evidence-based decision-making, the strengthening of legislation, the fostering of intersectoral cooperation and the adequate allocation of financial resources. Mechanisms for regulating harmful chemicals should be strengthened and WHO discussions should lead to a detailed analysis of the impact of chemicals on human health.

The representative of the UNITED REPUBLIC OF TANZANIA said that her country was participating fully in the implementation of the Strategic Approach and already had a number of laws and regulations on the management of chemicals. However, there were still gaps in capacities for monitoring and assessing the impact of chemicals on health and the environment. She looked forward to increasing core capacity building in that respect. She supported the adoption of the draft resolution.

The representative of THAILAND supported the full implementation of the Strategic Approach and said that her country's fourth national strategic plan on chemical management was being implemented. It was important for WHO to support Member States by enhancing individual, institutional and network capacities and drawing lessons from evidenced-based best practices. She invited Member States to adopt the draft resolution, of which Thailand was a cosponsor.

The representative of the UNITED STATES OF AMERICA highlighted the importance of health sectors in the sound management of chemicals, the Strategic Approach and the Sustainable Development Goals. She supported the draft resolution and looked forward to working with other Member States to manage chemicals and protect human health.

The representative of SOUTH AFRICA, referring to the policy and regulatory measures and the multilateral agreements and voluntary mechanisms for the sound management of chemicals being implemented by her Government, said that national coordinating efforts for the sound management of chemicals included the establishment of the Multi-stakeholder Committee on Chemicals Management. Her country nevertheless continued to face numerous challenges and the involvement of the health sector was crucial.

The representative of SRI LANKA said that the increasing use of agrochemicals, food preservatives and other chemicals, and the resulting accumulation of toxic chemicals in human bodies, had played a major role in the increase of cancer and other serious diseases. Member States, manufacturers and consumers must work together to minimize those adverse effects. WHO should support developing countries in building relevant capacities.

The representative of CHINA, expressing support for the draft resolution, said that the Chinese environment and agriculture sectors cooperated closely. The production and use of high-risk chemicals was restricted and strictly regulated and such chemicals were gradually being substituted by other products.

The representative of JORDAN expressed support for the draft resolution. The import of hazardous chemicals must be regulated, including by adopting relevant customs control legislation. The preparation of a list of hazardous chemicals, strict control of all sectors using chemicals, and sound management of toxic waste were also crucial.

The representative of ARGENTINA, also expressing support for the draft resolution, said that, in the light of rising mortality rates associated with chemicals, the involvement of the health sectors in

chemicals management was essential. The work of the Intergovernmental Forum on Chemical Safety had been particularly useful for low- and middle income countries; a reference to the Forum should be included in the draft resolution to give recognition to its important work.

The representative of INDONESIA said that the measures taken by her Government to manage chemicals soundly and to protect the population from hazardous substances included the introduction of non-incineration technologies for medical waste treatment to reduce the production of dioxin and the development of a national action plan to eliminate the use of mercury in small-scale gold mining. The establishment of a poison centre was in the pipeline.

The representative of MEXICO, supporting the draft resolution, agreed that health sector participation was crucial. His Government had taken a range of legislative measures to enhance the sound management of chemicals, including the adoption of a law whereby the cost of registering pesticides and plant nutrients was commensurate with their toxicity. He welcomed the report's focus on action and the proposal to develop globally-harmonized methods for chemical risk assessment, reduce duplication of effort, and improve the ability to access, interpret and apply scientific knowledge.

The representative of MOROCCO said that, despite progress made, the sound management of pesticides used in hygiene and public health remained a challenge. Furthermore, Morocco needed to build health sector capacities for chemical risk assessment, control and prevention and diagnosis and treatment capacities with respect to chemicals poisoning.

Ms Koivisto took the Chair.

The representative of URUGUAY said that the production and use of chemicals was projected to grow further, with the attendant environmental and health risks. Health must therefore be incorporated into policy-making across sectors. The health sector must be strengthened to help protect the most vulnerable segments of the population. The Government of Uruguay had undertaken a range of intersectoral coordination initiatives to reduce the adverse effects of chemicals on people's health. She urged Member States to adopt the draft resolution.

The representative of CHAD deplored the recurring chemical spills, in particular oil spills, which caused illness and death and destroyed flora and fauna. Health authorities in Chad had conducted a survey on natural environmental risk and risk associated with human activity. That information would be used as a basis for formulating a joint action plan for the health and environment sectors. WHO support for the implementation of the plan would be greatly appreciated.

The representative of PARAGUAY said that she supported the adoption of the draft resolution. The health sector must be given appropriate instruments to prevent and control the risks associated with chemicals and take part in decision-making on chemicals management. It must be involved in assessing the health and environmental impact of chemicals and decision-making on their market release and use. Health must be mainstreamed into all policies and strong WHO support was crucial.

The representative of MALAYSIA drew attention to the legislative and other measures adopted by his Government to ensure sound chemicals management and protect workers' health. Malaysia's National Poison Centre provided crucial information for professionals and the public on the detection and treatment of chemicals poisoning. Regulatory authorities, industry, retailers, research institutions and users were major stakeholders must play an important role in accelerating better chemicals management.

The representative of MALDIVES said that his country lacked the capacity to monitor the use and disposal of chemicals and assess their adverse health effects. In order to attain the Sustainable Development Goals, the country must minimize the adverse impacts of chemicals on human health and support in that respect from WHO, Member States and others was vital.

The representative of UNEP said that urgent action was required by all stakeholders to attain the 2020 goal. She recalled that the International Conference on Chemicals Management, at its fourth session, had called on WHO to “continue supporting the work of the secretariat in its areas of expertise by reassigning a staff member to the secretariat at the earliest date possible”. Similar calls had been made by UNEP Member States at the Second Meeting of the United Nations Environment Assembly. The Sixty-ninth World Health Assembly provided a timely opportunity for WHO Member States to respond to those calls. Given the challenges ahead, an adequately-resourced Strategic Approach secretariat was vital. Policy deliberation on sound chemicals management would remain topical beyond 2020 and the health sector must remain involved.

The observer of CHINESE TAIPEI briefed the Committee on measures and bodies established in Chinese Taipei to regulate hazardous chemicals and share relevant information. The impact of toxic chemicals on humans and the environment could affect generations and more sophisticated chemical management was crucial to ensure future well-being.

The representative of the UNION FOR INTERNATIONAL CANCER CONTROL, speaking at the invitation of the CHAIRMAN, said that there was growing evidence that exposure to harmful chemicals increased the likelihood of noncommunicable diseases; such diseases should therefore be taken into account in the development of the proposed road map. WHO should invest in research and the sharing of data on links between noncommunicable diseases and chemicals exposure in order to support an informed and coordinated response. Civil society should be brought on board in the development and implementation of the road map.

The ASSISTANT DIRECTOR-GENERAL (Family, Women’s and Children’s Health), noting that the sound management of chemicals brought substantial health benefits and that emphasis had been placed during the discussion on the link between health and other sectors and the importance of collaboration between the United Nations agencies, said that it was important to look beyond goal 3 of the 2030 Agenda for Sustainable Development to other goals that addressed essential determinants of health. The Secretariat looked forward to working with Member States and other stakeholders on the development of the proposed road map.

The draft resolution was approved.¹

The meeting rose at 12:55.

¹ Transmitted to the Health Assembly in the Committee’s fourth report and adopted as resolution WHA69.4.

ELEVENTH MEETING

Friday, 27 May 2016, at 14:35

Chairman: Mr M. BOWLES (Australia)

later: Ms T. KOIVISTO (Finland)

later: Mr M. BOWLES (Australia)

NONCOMMUNICABLE DISEASES: Item 12 of the agenda (continued)

Report of the Commission on Ending Childhood Obesity: Item 12.2 of the agenda (document A69/8)

The CHAIRMAN drew attention to a draft decision proposed by the delegations of Australia, Canada, Colombia, Ecuador, Ghana, Malaysia, Mexico, Monaco, Thailand and Zambia, which read:

The Sixty-ninth World Health Assembly, having considered the report of the Commission on Ending Childhood Obesity,¹ decided:

- (1) to welcome the report of the Commission on Ending Childhood Obesity;
- (2) to invite all relevant stakeholders, including international organizations, nongovernmental organizations, philanthropic foundations, academic institutions and the private sector, to work towards implementation of the actions recommended in the report of the Commission on Ending Childhood Obesity, as appropriate, according to context, with a view to strengthening their valuable contribution to ending childhood and adolescent obesity;
- (3) to recommend that Member States develop national responses to end childhood obesity and adolescent obesity, taking into account the recommendations included in the report of the Commission on Ending Childhood Obesity and adapting them to their national context;
- (4) to request the Director-General to develop, in consultation with Member States² and relevant stakeholders, an implementation plan guiding further action on the recommendations included in the Report of the Commission on Ending Childhood Obesity to be submitted, through the Executive Board at its 140th session, for consideration by the Seventieth World Health Assembly.

¹ Document A69/8.

² And, where applicable, regional economic integration organizations.

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

Decision: Report of the Commission on Ending Childhood Obesity			
A. Link to the general programme of work and the programme budget			
1. Please indicate to which impact and outcome in the Twelfth General Programme of Work, 2014–2019 and which output in the Programme budget 2016–2017 this draft decision will contribute if adopted. General Programme of Work: Category 2 Noncommunicable diseases. Programme budget 2016–2017: outcome 2.1 and outputs 2.1.1 and 2.1.2.			
2. If there is no link to the results as indicated in the Twelfth General Programme of Work, 2014–2019 and the Programme budget 2016–2017, please provide a justification for giving consideration to the draft decision. Not applicable.			
3. What is the proposed timeline for implementation of this decision? An implementation plan will be developed through the Executive Board at its 140th session for consideration by the Seventieth World Health Assembly (2017). <i>If the timeline stretches to future programme budgets, please ensure that further information is provided in the costing section.</i>			
B. Budgetary implications of implementation of the decision			
1. Current biennium: estimated budgetary requirements, in US\$ million			
Level	Staff	Activities	Total
Country offices	Not applicable	0.45	0.45
Regional offices	Not applicable	0.55	0.55
Headquarters	0.70	0.30	1.00
Total	0.70	1.30	2.00
1(a) Is the estimated budget requirement in respect of implementation of the decision fully included within the current programme budget? (Yes/No) Yes.			
1(b) Financing implications for the budget in the current biennium: – How much is financed in the current biennium? US\$ 1 million. – What are the gaps? US\$ 1 million. – What action is proposed to close these gaps? The gap will be addressed through coordinated resource mobilization effort.			

2. Next biennium: estimated budgetary requirements, in US\$ million.			
Level	Staff	Activities	Total
Country offices	Not applicable	Not applicable	Not applicable
Regional offices	Not applicable	Not applicable	Not applicable
Headquarters	Not applicable	Not applicable	Not applicable
Total	0	0	0
2(a) Financing implications for the budget in the next biennium: <ul style="list-style-type: none"> – How much is currently financed in the next biennium? Not applicable. – What are the financing gaps? Not applicable. – What action is proposed to close these gaps? Not applicable 			

The representative of TONGA, speaking on behalf of the Pacific island countries, said that tackling childhood obesity also provided an opportunity to reduce rates of heart disease, diabetes and other noncommunicable diseases, which were leading causes of deaths in Pacific island countries. As no single intervention alone would stop the growing obesity epidemic, it was important to apply a multisectoral approach in countries, with the necessary technical support from WHO. The report of the Commission on Ending Childhood Obesity would help to guide national efforts to prevent and control childhood obesity.

The representative of PANAMA said that she supported the Commission's recommendations, which were in line with action being taken in her country to reduce childhood obesity. Attaining that objective would require a multisectoral approach, with collaboration, in particular, between the health and education sectors. Political will at the highest level would be required to tackle the challenges posed by the interests of the business sector, especially with regard to ensuring the availability of healthy foods.

The representative of the UNITED STATES OF AMERICA, welcoming the recommendations, said that new tools, interventions and partnerships were need to address the challenge of overweight and obesity among children. She supported the draft decision, which encouraged a multisectoral approach. She acknowledged that childhood obesity was greatly influenced by food and nutrition, levels of physical activity, eating behaviour, cultural values and social environments, and that the private sector could play an important role in enhancing access to healthier food and promoting physical activity.

The representative of the UNITED KINGDOM OF GREAT BRITAIN AND NORTHERN IRELAND, welcoming the report, said that it was encouraging to see a wide-ranging debate taking place on childhood obesity. New tools and interventions were indeed needed to tackle the problem. Her Government would soon launch a national strategy that would take account of all the factors that contributed to childhood obesity.

The representative of GERMANY said that her country had initiated a number of measures to improve the lifestyle of children and their families and had adopted new legislation aimed at addressing childhood obesity and strengthening health promotion in community and school settings.

The representative of BAHRAIN, speaking on behalf of the Member States of the Eastern Mediterranean Region, said that the Region was fully committed to addressing childhood overweight and obesity. The Director-General should continue to emphasize the need to address the social determinants of the problem and to support the development of coherent policies across the trade, industry and health sectors to ensure a healthy food supply. Partnership with the private sector in combating childhood obesity should be encouraged, although conflicts of interest must be avoided. Efforts should be made to reduce children's exposure to the marketing of unhealthy foods and to ban their sale and marketing in schools. More guidance was needed on how to encourage policy-makers in other sectors to implement policy recommendations aimed at improving diets and promoting physical activity.

The representative of SOUTH AFRICA said that it was worrying that childhood obesity was increasing even in contexts of poverty. Her delegation welcomed the Commission's recommendations and wished to emphasize the importance of promoting exclusive breastfeeding and addressing environmental and social factors that contributed to obesity. WHO should play a more prominent role in dealing with the food industry and discouraging marketing strategies that promoted unhealthy food.

The representative of GHANA, speaking on behalf of the Member States of the African Region, said that the Region welcomed the whole-of-government approach embodied in the Commission's policy recommendations. Governments needed to ensure that policies across all sectors systematically took health into account to avoid harmful health impacts and improve population health. The fast food industry was growing in Africa, and regulation of the advertising and sale of unhealthy foods and sugar-sweetened beverages was needed. Taxes should also be imposed on such products. Early childhood development was a key determinant of obesity and related health problems later in life, and Member States should therefore adopt multisectoral and life course approaches to ensure the creation of environments conducive to healthy child development. He called on the Director-General to facilitate technical support in developing evidence-based national policies and building capacity for their implementation. The draft decision should be adopted.

The representative of JAPAN said that, as previous WHO efforts had focused mainly on child malnutrition, attention to childhood obesity was welcome. The problem should be addressed as a preventable cause of noncommunicable diseases in adulthood. Action taken on the recommendations on ending childhood obesity should be consistent with the guidelines set out in relevant plans and strategies, such as those relating to noncommunicable diseases and maternal, infant and young child nutrition. If an implementation plan was to be adopted, appropriate indicators would have to be developed in order to ensure monitoring and accountability. It should be borne in mind that the issue of labelling, addressed in the Commission's recommendations 1.6 and 1.7, was a sensitive one.

The representative of MALAYSIA said that soft policies introduced to date to address childhood obesity had not worked effectively, and her Government was therefore pleased that the Commission's report reflected the need for hard policies. Strong political will would be needed to ensure that such policies were implemented. In 2015 Malaysia had hosted a bioregional workshop on restricting the marketing of foods and beverages to children in the Western Pacific and South-East Asia. The participating countries were committed to implementing the actions identified during the workshop.

The representative of ICELAND said that the report of the Committee on Ending Childhood Obesity provided valuable guidance to Member States that would support the implementation of programmes to promote healthy foods and habits. No single intervention could halt the rising level of obesity, which was a major global challenge and a known risk factor for numerous other conditions.

The representative of CHILE said that her country was implementing a policy on food and nutrition that was in line with the Commission's recommendations. It had adopted a law on food labelling, requiring information on calories, sugar, sodium and saturated fats. The marketing, sale and giving away of such foods to children was also to be prohibited in schools and other settings frequented by children. Support from the Secretariat in evaluating the cost-effectiveness of various measures would be welcome, as evidence of effectiveness would make it easier to gain support for needed legislative, regulatory and fiscal measures.

The representative of SRI LANKA, speaking on behalf of the Member States of the South-East Asia Region, said that the countries in the Region faced the double burden of persistent undernutrition and increasing childhood obesity, which needed to be addressed simultaneously. Priority needed to be given to improving diets, promoting physical activity and combating the aggressive promotion of unhealthy food to children. A multisectoral, action-oriented approach was also needed. The countries of the Region supported the draft decision and were committed to implementing the Commission's recommendations.

The representative of SUDAN, noting that many developing countries, including his own, faced the double burden of malnutrition and obesity, said that the Commission's recommendations provided a basis for realistic interventions for tackling childhood obesity in a comprehensive manner that dealt with contributing factors such as policy and environment.

The representative of FINLAND expressed strong support for efforts to scale up action to tackle childhood obesity, without which obesity-related problems would continue to threaten the future health and well-being of individuals and societies. Prevention of obesity was simple in theory, but difficult to follow in practice, since children lived in obesogenic environments. Adults were responsible for allowing that environment to exist and must take action to change it. The marketing of unhealthy foods to children was an important issue to address, but it was also crucial to improve the quality of foods given to children, which was often of lower nutritional quality than food consumed by adults, with high levels of sugar, fat and salt. He supported the draft decision.

The representative of BARBADOS said that his country had incorporated several of the Commission's recommendations into its national action plan for preventing obesity in childhood and adolescence, including the promotion of exclusive breastfeeding and increased physical activity and the reduction of the marketing of unhealthy foods to children. An intersectoral approach was essential in addressing the social determinants of childhood obesity. He called on the Secretariat to provide technical support for the monitoring and evaluation of the plan and to allocate resources specifically to support developing countries in combating childhood obesity.

The representative of CHINA said that the report of the Commission on Ending Childhood Obesity could have been further enhanced through the inclusion of information on regional differences in indicators and standards. His Government supported the Commission's recommendation 6.1 on the provision of weight management services, but considered that the question of whether such services would be covered under national medical insurance should be decided in the light of national circumstances.

The representative of CANADA said that a critical aspect of the successful implementation of the recommendations would be sharing of best practices and lessons learned in developing and implementing domestic policies to improve health and reduce childhood obesity. The Secretariat should consider how best to facilitate such information-sharing in order to build the global evidence base. Her Government supported the draft decision and looked forward to supporting the Secretariat and other partners in developing the implementation plan.

The representative of the REPUBLIC OF KOREA said that action to tackle childhood obesity needed to address not only its effects on physical, psychological and social well-being, but also factors that led to obesity, such as food intake, nutritional imbalances and inactivity. Cognizant of the link between sugar consumption and obesity, her Government had introduced educational and other measures to reduce children's sugar intake and to restrict the marketing of high-calorie, low-nutrition foods. Food industry and consumer advocacy groups were cooperating with the Government in those efforts.

The representative of SURINAME, referring to recommendation 4.4 on support for breastfeeding in the workplace, said that Secretariat support in encouraging employers to facilitate the practice would be appreciated. Increased attention to the promotion of healthy diets was needed, especially since the food industry often sought to focus attention on lack of physical activity in order to divert attention away from high-calorie foods as a key determinant of obesity. The Secretariat should provide guidelines on how the health and education sectors might forge partnerships with food producers.

The representative of BRAZIL, welcoming the Organization's efforts to increase the visibility of the issue of childhood obesity, said that the Commission's recommendations were science- and evidence-based and would guide Member States as they developed and implemented measures to end childhood obesity. She supported the draft decision.

The representative of JAMAICA said that his Government had recently drafted a national plan for preventing and controlling obesity among children and adolescents that was in line with the Commission's recommendations. Relevant sectors, including the education sector and the food industry, had been engaged in promoting healthy lifestyles. However, protracted legislative and policy development processes and unsustainable or inconsistent implementation of programmes posed challenges. He urged WHO and other international organizations to advocate the necessary technical and financial support to enable countries, especially small island developing States, to implement the recommendations.

The representative of THAILAND, voicing strong support for the recommendations, said that a life course approach was needed to prevent obesity. At present, WHO recommendations on physical activity did not cover pregnant women or children under 5 years of age. Guidance should be expanded to cover those two groups in order to further promote physical activity and reduce sedentary lifestyles. The Secretariat should provide technical support to Member States for the development of plans to end childhood obesity.

The representative of NEW ZEALAND said that her Government had launched a childhood obesity plan in 2015 as part of its life course approach to noncommunicable diseases. Prenatal malnutrition and low birth weight could create a predisposition to obesity, heart disease and diabetes later in life. Improving care before and during pregnancy was therefore crucial for risk reduction. The prevention and control of childhood obesity required a whole-of-government approach, with innovative strategies across the health, education, agriculture, environment and economic development sectors.

The representative of MEXICO said that comprehensive, long-term action was needed to halt the rise in childhood obesity. Education had the power to inculcate attitudes for a lifetime, and children should therefore be educated on healthy life choices. Full use should be made of information technologies to inform the public and also to monitor and evaluate the effectiveness of actions undertaken. Legal provisions should be put in place to reduce the consumption of foods of limited nutritional value and regulate advertising of food products to children. A sustainable solution to childhood obesity would only be found with the involvement of all stakeholders.

The representative of the RUSSIAN FEDERATION said that reducing childhood obesity would have a positive impact on the elimination of noncommunicable diseases in adults and thus reduce premature mortality rates. Proper maternal and child nutrition was crucial and required concerted public awareness-raising efforts. Particular attention should be paid to adolescents, using an interdisciplinary approach and peer education activities. Her Government was developing a healthy schools programme, bringing together teachers, doctors, psychologists and experts in child health to promote healthy lifestyles, including healthy eating and physical activity.

The representative of INDONESIA said that measures had been taken in Indonesia to promote a comprehensive approach to improving nutrition, with a focus on the first 1000 days of life. Food labelling regulations required information on salt, sugar and fat content. Guidance had been developed on communication, information and education services for prevention and early detection of childhood obesity at the primary care level. Healthy eating campaigns had been conducted and nutritional surveillance had been improved.

The representative of COSTA RICA said that efforts were being made to address childhood obesity in Costa Rica. While the Commission's recommendations were sound, some Member States would require technical and financial assistance from relevant international organizations to ensure their implementation.

The observer of CHINESE TAIPEI said that to end childhood obesity clear targets must be set to hold politicians accountable; blame should not be placed on individuals, but rather on the food system, which should be changed. Legislation should be adopted to protect children against the marketing and sale of junk foods. Chinese Taipei required food labelling to show the sugar and calorie content of foods and drinks. Steps were being taken to eliminate the use of trans-fats by 2018. The creation of supportive environments for healthy eating and physical activity was an urgent priority. Healthy choices must be easy choices and therefore must be accessible, affordable and attractive.

The representative of UNDP said that rising levels of overweight and obesity constituted a major challenge to sustainable development and must be addressed through a multisectoral approach. With regard to fiscal policies to reduce the consumption of unhealthy foods, any revenue from food taxes should be used to finance multisectoral health responses. As lack of policy coherence regarding the operations of multinational corporations was a major threat to progress towards ending childhood obesity, ensuring the primacy of the right to health should be a main concern in policy and trade considerations. While WHO's leadership role should be recognized and supported, interagency collaboration for the prevention and control of noncommunicable diseases was essential, and the Commission's recommendations should be considered in the light of the work of the United Nations Inter-agency Task Force on the Prevention and Control of Non-communicable Diseases.

The representative of the GLOBAL HEALTH COUNCIL, speaking at the invitation of the CHAIRMAN, said that policies to promote breastfeeding, increase access to healthy foods and engage the media and other sectors in promoting healthy lifestyles should be encouraged. Partnerships should be established between government agencies, the private sector and civil society to prevent malnutrition in all its forms through a multisectoral approach. The adoption of a standardized global nutrient labelling system would facilitate comparisons between countries and mitigate the influence of industry forces on national dietary guidelines.

The representative of MEDICUS MUNDI INTERNATIONAL – INTERNATIONAL ORGANISATION FOR COOPERATION IN HEALTH CARE, speaking at the invitation of the CHAIRMAN, said that his organization welcomed the proposed recommendations in support of tax on beverages with high sugar content. Like taxes on tobacco, such taxes could have a powerful impact. Tax policies should be supported by investment to increase access to healthy foods and opportunities

for physical activity. Such investment could be subsidized from sugar tax revenue. It was regrettable that the report did not explicitly hold the food industry accountable for its role in the childhood obesity crisis. Greater regulation of the food industry was essential. He urged the Secretariat to acknowledge the role of private actors in accelerating the obesity crisis and to provide guidance for Member States on policy options to mitigate their impact.

The representative of the WORLD OBESITY FEDERATION, speaking at the invitation of the CHAIRMAN, called on Member States to implement the Commission's recommendations as a matter of urgency and on the Secretariat to provide technical assistance where necessary. The Federation strongly supported the development of an implementation plan with a robust monitoring and accountability framework. It encouraged Member States to promote healthy food options and prevent any undue influence of commercial interests on their policy decisions.

The PROGRAMME MANAGER (Surveillance and Population-based Prevention) thanked the Commission for its report and its six recommendations, and noted the Health Assembly's expressions of support for the recommendations. The report had been the outcome of extensive regional consultations, and the recommendations thus reflected the views of a broad range of Member States as to how best to prevent childhood obesity. Consideration was being given to how the Secretariat could support Member States, in particular by building on existing initiatives with regard to maternal, infant and child nutrition and noncommunicable diseases, including the WHO Global Strategy on Diet, Physical Activity and Health. The recommendations contained in the Commission's report were flexible and could be tailored to national situations; the Secretariat would provide an implementation framework and technical support where requested. It would also encourage sharing of information and best practices. He had taken note of the observation that WHO did not provide recommendations on physical activity for young children or pregnant women; the Secretariat would address that omission as part of the revision of the WHO recommendations on physical activity in 2017.

The CHAIRMAN took it that the Committee wished to approve the draft decision.

The draft decision was approved.¹

Draft global plan of action on violence: Item 12.3 of the agenda (documents A69/9 and EB138/2016/REC/1, resolution EB138.R3)

The representative of PAKISTAN, speaking in his capacity as the representative of the Executive Board, said that, at its 138th session, the Executive Board had considered the report by the Secretariat on the draft global plan of action on violence (document EB138/9). Some 25 participants had taken the floor, noting the crucial importance of the health sector's role in preventing and responding to violence and expressing their appreciation of the comprehensive, consultative manner in which the plan had been developed. The Board had endorsed the plan and adopted resolution EB138.R3, which contained a draft resolution recommending that the Health Assembly also endorse the plan of action.

The representative of the UNITED STATES OF AMERICA, speaking on behalf of the Member States of the Region of the Americas, commended the comprehensive consultation process, which had ensured that the draft plan of action was pertinent to all. The focus on violence against women, girls and children was particularly welcome and would make the plan of action a valuable tool for helping Member States to protect the most vulnerable members of society. While applauding the plan's emphasis on the role of the health sector in addressing negative health outcomes of violence, he

¹ Transmitted to the Health Assembly in the Committee's fourth report and adopted as decision WHA69(12).

pointed out that health systems should also play a role in prevention and in advocating a multisectoral approach. Violence against women was a serious consequence of gender inequality. Implementation of the global plan would contribute to a world without violence and to the attainment of the Sustainable Development Goals. The Member States of the Region looked forward to working with other Member States to implement the plan.

The representative of SOMALIA, speaking on behalf of the Member States of the Eastern Mediterranean Region, said that the health sector represented a key entry point for ending violence. The draft global plan of action focused on strengthening the role of the health sector, which was indeed important, but the need for a multisectoral approach could not be overemphasized. She called on the Director-General to support Member States in adapting and implementing the plan in accordance with national legislation, capacities, priorities and circumstances.

The representative of SWEDEN, speaking also on behalf of Canada, New Zealand, Thailand, Uruguay and Zambia, said that health systems had a key role to play in preventing violence, since health professionals were often the first point of contact for victims and provided not only medical care but vital guidance on where to turn for help. As research had shown that violence against women and girls was often linked to sociocultural norms, every effort must be made to challenge harmful gender stereotypes and end harmful traditional practices such as child marriages. WHO should facilitate the sharing of information and best practices in order to build the evidence base for successful violence prevention programmes. Member States should protect women's and girls' sexual and reproductive health and rights, particularly given the high numbers of deaths during pregnancy, childbirth, or as a result of unsafe abortions, all of which disproportionately affected poor women. Investment in empowerment, social justice and human rights was essential.

The representative of SRI LANKA said that his Government was already implementing measures described in the draft plan of action to protect women from violence. It had developed a training module to strengthen health service capacity to respond to survivors of gender-based violence and established care centres for survivors. A new programme for awareness-raising among newly married couples had been designed to educate them on the benefits of a family environment without violence, responsible sexual practices and men's participation in parenthood.

The representative of the UNITED KINGDOM OF GREAT BRITAIN AND NORTHERN IRELAND, welcoming the draft plan of action and draft resolution, said that tackling violence against women and girls, and against children, was a priority for his Government, which was working nationally and internationally to prevent early and forced marriage, female genital mutilation, sexual violence during conflict, violence against older people and child sexual exploitation, and to address other issues raised in the draft plan. His Government attached particular importance to guaranteeing sexual and reproductive health and rights for all and encouraged WHO to be active and vocal in that regard.

The representative of URUGUAY said that violence against women and children prevented them from enjoying their rights fully and was the result of asymmetrical relationships in patriarchal societies. Governments should work to uphold the rights of women and children to a life without violence, by mainstreaming a gender perspective in all policies. Efforts to prevent violence and promote women's rights must also be directed at men. Ending violence against women and children was crucial to the attainment of the Sustainable Development Goals. In Uruguay, a new national plan of action to address gender-based violence had been adopted and a multisectoral bill on the issue was currently before parliament. She supported the draft resolution.

The representative of JAMAICA, commending the plan of action, said that interpersonal violence constituted a major public health problem in Jamaica. Violence against health care workers was also a concern. Mechanisms and guidelines were needed to train members of the public health workforce to identify and treat victims of violence. WHO technical guidance on best practices for preventing violence against health care workers and strengthening health systems' capacity to identify and treat victims of violence would be appreciated. She supported the draft resolution.

The representative of AUSTRALIA welcomed the commitment of Member States to address violence, in particular against women and girls and against children. His Government had zero tolerance for violence, which had a devastating impact on individuals, families, communities and society as a whole, and was pleased that the draft plan of action reflected the need for a whole-of-society and whole-of government approach, with responses tailored to the needs of vulnerable groups.

The representative of ICELAND said that his Government was taking a new approach to domestic violence prevention that involved removing the perpetrator from the home and issuing restraining orders, to provide better protection for victims. First response was being improved through cooperation between the police and social services. The purchasing of sexual services and profiting from prostitution had been made illegal, but sex workers were not penalized. Iceland had signed, and intended to ratify, the Council of Europe Convention on preventing and combating violence against women and domestic violence. The plan of action would support efforts to end violence in all its forms, and he therefore supported the draft resolution.

The representative of CHILE said that her Government shared the vision of the plan of action and particularly appreciated the focus on a life course approach and human rights, gender equality, evidence-based policy-making, universal health coverage and public participation. Despite the seriousness of the problem, interpersonal violence did not receive sufficient attention at the national level. Support from WHO and other international organizations was therefore needed. Chile had established an interministerial commission on health and gender-based violence to review the national policy on the matter, expanding its scope and incorporating available scientific evidence. She supported the draft resolution.

The representative of the UNITED REPUBLIC OF TANZANIA, endorsing the draft global plan of action and the draft resolution, said that his Government was taking measures to integrate primary and secondary violence prevention into health programmes and ensure a comprehensive, evidence-based approach.

The representative of EQUATORIAL GUINEA, speaking on behalf of the Member States of the African Region, called on Member States to make a commitment to strengthen the capacity of their health systems to tackle the problem of interpersonal violence, in particular against women and girls and against children, and on WHO and other partners to provide technical and financial support for that purpose. The countries of the Region supported the draft resolution.

The representative of GERMANY said that the adoption of the global plan of action on violence would be an important milestone. The consultation process through which the plan had been drafted had been exemplary and the vision and goals well chosen. The plan provided useful guidance for Member States, particularly for training health professionals and coordinating support systems. She encouraged all Member States to implement the action plan, which would be crucial for the attainment of the Sustainable Development Goals.

The representative of THAILAND said that the challenges posed by interpersonal violence required a coordinated multisectoral response, in line with the principles of a Health in All Policies approach. Effective information systems would be required to track progress with regard to the

implementation of the global action plan, and developing countries would need technical support in that regard. The implementation of the global plan, with high-level political cooperation and social participation, would be crucial for the attainment of the Sustainable Development Goals.

The representative of CHINA said that the role of the health system in curbing violence, in particular against women and children, was key. She welcomed the acknowledgement in the draft plan of action of the importance of adapting anti-violence measures to local contexts. China had recently adopted a law on the prevention of domestic violence. Measures to prevent interpersonal violence must be taken using a multisectoral approach, with enhanced cooperation. The adoption of the plan of action would consolidate the health sector response to violence, support the collection of data and evidence and improve intersectoral coordination.

The representative of CANADA, expressing support for the draft resolution, said that her Government applauded WHO's leadership in the drafting of the global action plan, which clearly recognized violence as a public health issue. She commended the significant efforts made to ensure that the global plan was grounded in evidence and provided clear and practical guidance for Member States to respond effectively to violence against women and children. As guidance and training on the implementation of the plan would be useful, Canada had provided funds to WHO to develop guidelines and a curriculum on the health sector response to child maltreatment.

The representative of MONACO said that her country's national policies were fully in line with the draft global plan of action. Medical services for victims of violence worked with social and law enforcement services and civil society. Particular attention was paid to prevention through awareness-raising activities for society as a whole and through school programmes for children. She supported the draft resolution.

The representative of VIET NAM said that she welcomed the draft resolution's acknowledgement of the key role of the health system in addressing interpersonal violence. Medical interventions, however, should not be a substitute for more holistic approaches aimed at protecting the individual's dignity and mental and social well-being. She urged the Secretariat to develop guidelines to support health systems in providing such approaches at the first point of contact.

The representative of COSTA RICA said the draft resolution would provide a road map for countries to set priorities for the prevention of violence against women and children. Costa Rica had been a pioneer in tackling violence against women and children, both through the health sector and through cooperation with relevant institutions. The problem should be treated as a priority for health, public safety and social development.

The representative of SWITZERLAND, welcoming the extensive consultations carried out to finalize the global plan of action, said that her Government attached great importance to curbing violence, especially against women and children, and supported the draft resolution.

The representative of MEXICO said that the strategic directions and activities envisaged under the plan of action would boost the capacity of health systems to address the problem of violence against women and children. Midterm goals to be met before 2030 should be established with a view to tracking progress and identifying any potential barriers that would hinder full achievement of the plan's objectives.

The representative of the RUSSIAN FEDERATION said that she appreciated the Secretariat's efforts to improve the draft plan of action and take into account the positions of Member States. Her Government was working to stop violence against women and children, which required action on the part of various sectors, with the health system playing a key role. Medical personnel were required to

screen for signs of violence and report suspected cases to law enforcement officials. Schools and antenatal clinics also played an important role in identifying cases of violence.

The representative of INDONESIA said that her Government was continuing to strengthen its legislation and policies to respond to the problem of violence against women and children. The identification of cases of violence at the primary care level should be improved, supported by better reporting systems. She fully supported the draft plan of action.

The representative of PANAMA said that violence was both a health and a social problem. The cooperation of many governmental departments and nongovernmental and community organizations was needed to tackle the problem. It was of the utmost importance to develop strategies to prevent violence and provide treatment and rehabilitation for victims. Particular attention should be given to vulnerable groups, including older and disabled persons. She supported the draft plan of action.

The representative of TURKEY said that his Government had actively contributed to the drafting of the Council of Europe Convention on preventing and combating violence against women and domestic violence, the most far-reaching international treaty on the subject. Although it was an instrument of the Council of Europe, any Member States of the United Nations could be a party to the Convention, which established a legally binding definition of violence against women. One chapter was devoted to women migrants and asylum seekers who faced gender-based violence. He welcomed the global plan of action and supported the draft resolution.

The representative of SURINAME said that strengthening the capacity of health systems to address violence would be a long process, requiring change in societies. The plan's four strategic directions should be incorporated in the development of national policies. Protocols and operating procedures to strengthen the response of health systems should also be developed. She supported the adoption of the draft resolution, but highlighted the need not to overlook the problem of violence among men, especially young men.

The representative of PARAGUAY said that her Government welcomed the draft plan of action but would require support from the Secretariat in order to make the necessary adjustments in its plans and programmes. The plan would succeed only with high-level political commitment and the participation of civil society and various governmental institutions. Adequate financial and human resources would also be needed to meet the commitments set out in the plan.

The representative of MALDIVES said that her Government had developed a framework for the health system's response to domestic and interpersonal violence. Legislation had been enacted in 2013 and was being implemented. Efforts to raise community awareness of violence had been carried out, and the reporting of violence had increased. She supported the adoption of the draft resolution.

The observer of CHINESE TAIPEI said that Chinese Taipei had implemented laws and allocated funds for violence prevention. Multisectoral coordination mechanisms involving the health sector, the police, social services, and the education and labour sectors were in place. Chinese Taipei stood ready to play a key role in violence prevention and control at the global level.

The representative of the GLOBAL HEALTH COUNCIL, speaking at the invitation of the CHAIRMAN, said that the Council was strongly in favour of strengthening the role of health systems in a multisectoral response to interpersonal violence. To prevent violence and respond to the needs of child survivors, health care systems should be equipped to provide essential medical care, including treatment of post-traumatic stress disorder. In addition, health care workers should be trained to identify and respond to signs of abuse and violence, and emergency response systems should be equipped to meet the specific needs of children.

The representative of the INTERNATIONAL COUNCIL OF NURSES, speaking at the invitation of the CHAIRMAN, said that nurses played a valuable role in addressing violence, as they were often the first point of contact for victims. Education was key, as educated girls and women were more likely to resist abuse. A multisectoral response was required to develop and implement zero-tolerance policies and programmes. The Council was committed to working with governments to implement the plan of action.

The representative of the INTERNATIONAL PEDIATRIC ASSOCIATION, speaking at the invitation of the CHAIRMAN, and also on behalf of the International Society for the Prevention of Child Abuse and Neglect, said that the two organizations would work to ensure that child protection was included in training for all children's health workers. UNICEF and WHO should continue to emphasize obligations under the United Nations Convention on the Rights of the Child and related agreements. Countries should enact and enforce laws that protected the well-being of children. Prevention of violence against children in wars, in communities and in the home should be recognized as a priority in nation-building strategies.

The representative of the INTERNATIONAL PHARMACEUTICAL FEDERATION, speaking at the invitation of the CHAIRMAN, said that pharmacies provided easy access to advice on health issues and could support victims in reporting violence and seeking help. The majority of pharmacists were women, making it easier for them to converse with women victims of violence. Pharmacists in several countries were collaborating in programmes for the detection and reporting of interpersonal violence.

The representative of the INTERNATIONAL PLANNED PARENTHOOD FEDERATION, speaking at the invitation of the CHAIRMAN, said that pregnant women could be especially vulnerable to violence. There was a shortage of health workers able to address sexual and physical violence against women, and many women were left without support and services. Moreover, they might be further stigmatized by health care workers. The global plan set out a clear path for ending violence against women and girls in accordance with the 2030 Agenda for Sustainable Development. However, political support and financial commitment would be needed to turn the plan into action.

The representative of the WORLD MEDICAL ASSOCIATION, INC., speaking at the invitation of the CHAIRMAN, said that addressing violence required specific strategies tailored to the populations exposed. Violence against women was a manifestation of structural inequalities between the sexes and required targeted policies. She urged Member States, WHO and other United Nations agencies to intensify their response in that regard. Research was needed to identify effective health care strategies within a multisectoral response plan. The health sector should expand its role in preventing violence, ensure the quality and reach of prevention programmes and increase access to services for victims, and the medical profession should ensure the integration of violence prevention into medical school curricula.

The representative of the WORLD FEDERATION FOR MENTAL HEALTH, speaking at the invitation of the CHAIRMAN, said that she was pleased to see that the plan of action integrated mental health care into the overall health response to violence. The plan also acknowledged the need for research and recommended the adoption of evidence-based programmes to prevent violence. She welcomed WHO's support for such research through the Violence Prevention Alliance.

The representative of WORLD VISION INTERNATIONAL, speaking at the invitation of the CHAIRMAN, and also on behalf of The Save the Children Fund, urged Member States to adopt the draft resolution. Preventing and addressing violence in childhood could yield major benefits for both the individual and society. The draft global plan sought to ensure child-sensitive approaches and recognized that successful prevention must address the structural causes of violence, including cultural

norms and attitudes. The plan's alignment with the Sustainable Development Goals offered a unique opportunity to galvanize political will and mobilize wide-ranging social support to end violence against girls and boys.

The representative of HANDICAP INTERNATIONAL, speaking at the invitation of the CHAIRMAN, said that he welcomed the draft plan's recognition of the disproportionate vulnerability of certain populations to violence because of social exclusion, marginalization, stigma and discrimination. He was particularly pleased to note the frequent reference to the need to address violence against persons with disabilities. He urged the Secretariat and Member States to continue to put emphasis on persons with disabilities in the implementation of the plan.

The ASSISTANT DIRECTOR-GENERAL (Family, Women's and Children's Health) said that the statistics on violence against women and children were shocking. One in three women experienced violence in their lifetime, and 25% of children were exposed to violence or abuse. Violence had devastating consequences on the health and well-being of women and children, and was also a profound violation of their rights. The discussions that had culminated in the development of the global plan of action on violence had involved extensive consultations over a two-year period, and had already achieved the objective of raising awareness of the magnitude of the problem. Now it was time to translate anger about and zero tolerance of violence into concrete action by adopting and implementing the global plan of action. The plan was a road map to be used within national development plans in addressing the Sustainable Development Goals. Its multisectoral approach took into consideration the role of sectors other than health in addressing the problem.

For the Secretariat, the development of the plan had been an incredible journey, involving staff across departments, clusters and regions. The Secretariat was committed to continuing to measure the prevalence of violence and publishing data, developing and testing effective interventions and ensuring the availability of training and tools for health workers. It would work with Member States to achieve the vision of a world in which all women and children had the right to live, thrive and achieve their potential.

The ASSISTANT DIRECTOR-GENERAL (Noncommunicable Diseases and Mental Health), underscoring the important role of men in countering violence against women, said that Member States deserved much of the credit for the development of the draft global plan of action. As Member States moved into the implementation phase, the Secretariat would strive to ensure that they had the tools needed to work as effectively as possible. Member States also deserved credit for ensuring that the issue of violence against women and children was addressed in the Sustainable Development Goals. That historic accomplishment was the result of much collective effort.

The CHAIRMAN took it that the Committee wished to approve the draft resolution contained in resolution EB138.R3.

The draft resolution was approved.¹

Prevention and control of noncommunicable diseases: responses to specific assignments in preparation for the third High-level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable diseases in 2018: Item 12.4 of the agenda (documents A69/10 and EB138/2016/REC/1, resolution EB138.R4)

The representative of MALTA, speaking in his capacity as the representative of the Executive Board, said that the Executive Board, at its 138th session, had considered the report by the Secretariat

¹ Transmitted to the Health Assembly in the Committee's fourth report and adopted as resolution WHA69.5.

on its response to specific assignments given by the United Nations General Assembly and the World Health Assembly to the Secretariat in preparation for the third High-level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases in 2018 (document EB138/10). A total of 21 Member States had taken the floor to express their continued commitment to implement the road map of national commitments included in the 2011 Political Declaration on the Prevention and Control of Non-communicable Diseases and the 2014 outcome document adopted by the United Nations General Assembly in New York (General Assembly resolution 68/300). They had underscored the importance of technical assistance from WHO and other organizations of the United Nations system in preparing for the third High-level Meeting. Member States had welcomed the process proposed by the Secretariat to update the menu of policy options for the prevention and control of noncommunicable diseases and the process proposed to develop an approach for registering and publishing contributions of non-State actors to the achievement of the noncommunicable disease targets. The Board had recommended the adoption of the draft resolution contained in resolution EB138.R4.

The representative of MONACO said that she wished to propose amendments to the draft resolution with the aim of reflecting recent developments, in particular with regard to the global coordination mechanism on the prevention and control of noncommunicable diseases. The amendments, which would have no financial implications for the Secretariat, would read:

OP3bis. “NOTES that the Director-General has received two reports of the Working Groups of the WHO Global Coordination Mechanism on the Prevention and Control of NCDs to recommend ways and means of encouraging Member States to realize the commitment included in paragraphs 44 and 45(d) of the 2011 Political Declaration of the High-level Meeting of the United Nations General Assembly on the Prevention and Control of NCDs, as per footnote 4 under action 3.1 and footnote 5 under action 5.1 in Annex 5 of document A69/10.”

OP4.3 “[requests the Director-General] to continue to provide, upon request, technical support to Member States to strengthen their efforts to implement national NCD responses, including in the areas covered by the two reports of the Working Groups of the WHO Global Coordination Mechanism on the Prevention and Control of NCDs, within the parameters set out in the programme budget.”

The representative of the UNITED STATES OF AMERICA, commending the Secretariat’s work to fulfil the assignments given to it by the Health Assembly and the United Nations General Assembly, said that the global coordination mechanism was proving a valuable means of advancing multistakeholder action on noncommunicable diseases. He particularly appreciated the stepwise approach taken by the Secretariat, addressing financing and private-sector engagement in the first year and exploring ways of integrating noncommunicable diseases in other health programmes and enhancing international cooperation in the second year. He supported the draft resolution, with the amendments proposed by the representative of Monaco.

The representative of TONGA, speaking on behalf of the Pacific island countries, said that noncommunicable diseases posed the greatest challenge to the achievement of development goals for Pacific island countries and were therefore a priority for their leaders, who had taken a number of actions, including the implementation of multisectoral, country-specific road maps on tobacco and alcohol control; interventions to reduce consumption of unhealthy foods and drinks; and measures to strengthen of the evidence base in order to enhance the effectiveness of programmes and the efficiency of spending on prevention and control of noncommunicable diseases. Pacific island nation leaders would continue to work together to address noncommunicable diseases.

The representative of SURINAME, noting that her Government had recently used the WHO salt reduction toolkit as the basis for an action plan to reduce salt consumption, said that the development of a proposal for registering the contributions of non-State actors was welcome. She agreed that such registration should not be used to serve the interests of non-State actors or to promote their brands, products, views or activities if they did not contribute to the prevention and control of noncommunicable diseases. She supported the draft resolution, but suggested the inclusion of a reference to the promotion of a Health in All Policies approach, which would facilitate intersectoral collaboration.

The representative of OMAN said that, in April 2015, Oman had hosted a joint mission comprising representatives of five organizations of the United Nations system, which had met with members of parliament and representatives of the private sector and civil society, and which had resulted in the adoption of an action plan on the prevention and control of noncommunicable diseases. He reaffirmed Oman's commitment to the implementation of that action plan.

The representative of the CONGO, speaking on behalf of the Member States of the African Region, said that the African countries bore a heavy burden of noncommunicable diseases; however, epidemiological data on such diseases was lacking in most Member States of the Region. Mitigating the risk factors of noncommunicable diseases was also a significant challenge for the Region, owing to the high costs involved. Careful preparation would be required in order to reach a technical consensus prior to the third High-level Meeting in 2018. He suggested that the Director-General should set up a working group to draft a decision on reducing the harmful use of alcohol as a risk factor for noncommunicable diseases, to be submitted first to the Executive Board at its 140th session and then to the Health Assembly.

The representative of TIMOR-LESTE said that, with support from the Regional Office for South-East Asia, his Government had implemented a national action plan on noncommunicable diseases in alignment with the nine voluntary global targets, and had introduced the WHO Package of Essential Noncommunicable Disease Interventions as part of its primary health care package. It would welcome continued support from WHO on the issue. He supported the draft resolution.

The representative of CHINA, expressing support for the draft resolution, said that noncommunicable disease control had been included in her Government's 10-year health plan. While she supported WHO leadership on noncommunicable disease and control, collaboration with other international organizations should be enhanced. Greater support should be provided to developing countries and the establishment of prevention and control programmes promoted. Surveillance systems should also be strengthened.

The representative of LEBANON, speaking on behalf of the Member States of the Eastern Mediterranean Region, said that the Region had made progress in the prevention and control of noncommunicable diseases, but challenges remained with regard to intersectoral coordination, especially in countries affected by political instability and humanitarian emergencies. She urged the Secretariat to complete and share with Member States the work on "best buys" referred to in Appendix 3 to the global action plan. Many countries had capacity gaps in noncommunicable disease surveillance, and were not yet implementing the WHO global monitoring framework for noncommunicable diseases. The countries of the Region looked to the Secretariat for support in that regard and also for support in preparing for the 2018 High-level Meeting. A key issue was lack of guidance on addressing noncommunicable diseases as part of emergency preparedness, response and recovery. The Regional Office for the Eastern Mediterranean was developing such guidance, but it should be a priority for the Organization as a whole.

The representative of the UNITED KINGDOM OF GREAT BRITAIN AND NORTHERN IRELAND said that her Government was taking a wide range of actions to address the risk factors for noncommunicable diseases, including the implementation of standardized packaging for tobacco products and plans to introduce a sugar levy in 2018. The Government also supported developing countries in combating the issue through health system strengthening, capacity-building and access to essential medicines and equipment. She supported the draft resolution and the amendments thereto proposed by the representative of Monaco.

Ms Koivisto took the Chair.

The representative of SRI LANKA said that his Government had launched a five-year action plan with a view to attaining the global targets on noncommunicable diseases. He endorsed the statement made by the representative of the Congo and believed that an instrument similar to the WHO Framework Convention on Tobacco Control was needed in relation to alcohol, as the cross-border advertising and marketing of alcoholic beverages was becoming increasingly common.

The representative of BOTSWANA said that a multisectoral and multipronged approach had been adopted in her country to mitigate the risk factors of noncommunicable diseases, including the introduction of a Health in All Policies initiative and the revitalization of community health structures. Recognizing the role that harmful use of alcohol played as a risk factor in the epidemic of noncommunicable diseases, she called on the Director-General to study, in consultation with Member States, the necessity and feasibility of a legally-binding instrument to strengthen the public health response to the harmful use of alcohol and to report through the Executive Board to the Seventy-first World Health Assembly. She supported the draft resolution and the proposed amendments.

The representative of the REPUBLIC OF KOREA said that her Government planned to reflect the voluntary global targets in its prevention goals for major noncommunicable diseases. As part of efforts to reduce risk factors, it also planned to increase excise taxes on tobacco. It welcomed information-sharing as a means for countries to share their achievements and experience.

Mr Bowles resumed the Chair.

The representative of BRUNEI DARUSSALAM said that her Government was committed to implementing the four time-bound measures for 2015 and 2016 identified in the outcome document of the high-level meeting of the United Nations General Assembly in 2014, including by reducing premature mortality from noncommunicable diseases by one third by 2030. It welcomed proposed updates to the policy options and interventions set out in Appendix 3 to the global action plan and the development of an approach to register the contribution of non-State actors. Further technical support from WHO in strengthening national capacity to respond to prevention and control challenges would be welcome.

The representative of THAILAND, endorsing the proposal by the representative of Botswana, said that alcohol use was the root cause of noncommunicable diseases, violence and other problems. Improving country-level surveillance and mortality data collection should be a top priority in the fight against noncommunicable diseases. WHO should develop a composite risk index for noncommunicable diseases and promote a “total risk” approach. Calling for more role models from the Secretariat and from among global health leaders to promote healthy organizations, cities and countries, he expressed support for the draft resolution.

The representative of INDONESIA said that the list of policy options contained in Appendix 3 to the global action plan should be reviewed and updated, with due regard to country-specific situations. Her Government had undertaken significant efforts to prevent and control

noncommunicable diseases, such as the launch of an intersectoral healthy lifestyle initiative. The Secretariat should coordinate follow-up to the draft resolution in due course.

The representative of SOUTH AFRICA said that her Government was implementing key strategies to address the risk factors for noncommunicable diseases, such as the introduction of a tax on sugar-sweetened beverages and the adoption of regulations on salt and trans-fats. She supported the proposal to initiate a consultation process with a view to developing an international instrument on the harmful use of alcohol.

The representative of NORWAY said that the partnership dimension of the fight against noncommunicable diseases should be strengthened, in line with the 2030 Agenda for Sustainable Development. It was to be hoped that the Ninth Global Conference on Health Promotion would give impetus to efforts to promote healthy lifestyles as a means of preventing noncommunicable diseases. He endorsed the proposed method for updating Appendix 3 to the global action plan.

The representative of PARAGUAY said that her country had launched a multisectoral national plan for the prevention and control of noncommunicable diseases that incorporated the nine voluntary targets. Efforts had been made to raise awareness in other sectors in line with the plan's social determinants approach, but support from WHO and other organizations of the United Nations system in that regard would be welcome. Greater technical support from WHO was needed to assess the cost-effectiveness of interventions contained in Appendix 3 to the global action plan.

The representative of the DOMINICAN REPUBLIC said that his Government was implementing legislative measures in fulfilment of the commitments established in the Political Declaration of the High-level Meeting of the United Nations General Assembly. It had also adopted plans and guidelines for the reduction of salt, sugar and trans-fat consumption and for the promotion of physical activity and healthy lifestyles. He supported the draft resolution.

The representative of BRAZIL said that noncommunicable diseases were a public health challenge requiring a coordinated, structured response that took account of social determinants of health. She underscored the importance of further strengthening international cooperation to support national prevention and control efforts. The High-level Meeting in 2018 would require concerted action by Member States and the Secretariat to identify ways of addressing the challenges posed by noncommunicable diseases.

The representative of the RUSSIAN FEDERATION said that her Government had set up a State body to coordinate all work being done to promote healthy lifestyles and reduce noncommunicable diseases. She supported the draft resolution and the proposed amendments. WHO should continue to provide leadership on noncommunicable diseases at the global level and coordinate action with other organizations of the United Nations system.

The representative of IRAQ said that progress reports on noncommunicable disease prevention and control efforts should be prepared annually. Reports and expertise should be exchanged at the intraregional and interregional levels to ensure full preparedness for the High-level Meeting in 2018. His Government had developed a strategic workplan on noncommunicable diseases with the participation of various ministries and completed a survey on risk factors.

The representative of SENEGAL said that her country had an integrated national plan to prevent and control noncommunicable diseases that took account of strategic plans on cancer, diabetes and other disease and also addressed risk factors. It had conducted a STEPS survey of risk factors for noncommunicable diseases.

The representative of PANAMA said that she supported the draft resolution and the proposed amendments.

The representative of TURKEY thanked the United Nations Inter-agency Task Force on Non-communicable diseases for conducting a field assessment in Turkey.

The observer of CHINESE TAIPEI said that a number of actions had been taken in Chinese Taipei to attain the voluntary global targets and mitigate the risk factors for noncommunicable diseases, including the establishment of targets and monitoring indicators and the development of multisectoral plans. A health surcharge on tobacco products had also been imposed, with the revenue being used for noncommunicable disease prevention and control.

The observer of the INTERNATIONAL FEDERATION OF THE RED CROSS AND RED CRESCENT SOCIETIES said that, in preparation for the High-level Meeting in 2018, further attention should be given to the valuable role of volunteers in promoting healthy lifestyles in local communities and also to the role of community health workers in supporting lifelong preventive behaviour changes and providing care for individuals with chronic illnesses.

The representative of the ALLIANCE FOR HEALTH PROMOTION, speaking at the invitation of the CHAIRMAN, said that, in order to successfully address noncommunicable diseases, a holistic approach to the social determinants of health and strong preventive measures based on community health education and services were essential. Changes in health financing and public engagement, and a more widespread multisectoral and interpersonal approach were also needed. In the preparations for the 2018 High-level Meeting, she encouraged Member States to pay serious attention to the involvement of civil society.

The representative of ALZHEIMER'S DISEASE INTERNATIONAL, speaking at the invitation of the CHAIRMAN, called for Member States to fast-track action to achieve the 2025 voluntary targets and lay the groundwork for a successful High-level Meeting. Member States should implement the four time-bound national commitments for 2015 and 2016, establish and improve surveillance and monitoring systems and support the development of a purpose code for noncommunicable diseases to track development assistance for noncommunicable disease prevention and control.

The representative of the WORLD DENTAL FEDERATION, speaking at the invitation of the CHAIRMAN, said that oral disease should be addressed in all strategies and action plans on noncommunicable diseases and that an oral health dimension should be included in the discussions at the 2018 High-level meeting. A recent publication by the Regional Office for Africa on promoting oral health in Africa as an essential intervention in noncommunicable disease control could serve as a model for integrating oral disease into action plans on noncommunicable diseases.

The representative of the GLOBAL HEALTH COUNCIL, speaking at the invitation of the CHAIRMAN, said that surveillance systems for noncommunicable diseases should disaggregate data by age and sex. Children and adolescents faced unique challenges with regard to the prevention, treatment and management of noncommunicable diseases and required solutions tailored to their needs. Antenatal visits offered an opportunity to screen for noncommunicable diseases and provide integrated services.

The representative of INTERNATIONAL BABY FOOD ACTION NETWORK, speaking at the invitation of the CHAIRMAN, said that the global coordination mechanism had set harmful precedents that threatened WHO's credibility, integrity and effectiveness, and seemed to grant access to almost any business while excluding some critical nongovernmental organizations. The mechanism

had failed to make any significant progress in curbing harmful marketing practices and, moreover, had promoted partnerships with corporations that promoted unhealthy foods.

The representative of the INTERNATIONAL FEDERATION OF MEDICAL STUDENTS' ASSOCIATIONS, speaking at the invitation of the CHAIRMAN, said that noncommunicable diseases were a cross-cutting issue requiring a Health in All Policies and whole-of-government approach. She called on the private sector to recognize the potential health threats of products such as processed foods, alcohol and tobacco and encouraged governments to introduce legislation limiting public exposure to such risk factors. Since there was little donor funding for noncommunicable disease prevention and control, governments should seek opportunities for triangular cooperation. Governments should also increase youth involvement through youth-orientated awareness programmes at local, regional and international levels.

The representative of MEDICUS MUNDI INTERNATIONAL – INTERNATIONAL ORGANISATION FOR COOPERATION IN HEALTH CARE, speaking at the invitation of the CHAIRMAN, said that decision-making on noncommunicable disease efforts had become very complicated, with multiple overlapping mandates and forums, which was of concern. He encouraged WHO to move from self-review of progress by Member States to an independent reporting system that included peer review. Noting the lack of data with respect to progress on the nine voluntary global targets, he urged the Secretariat to review its approach to reporting. In the revision of Appendix 3 to the global action plan, the Secretariat should also examine trade and health policy coherence and the development of capacity in that regard, including through guidelines for assessing the health impact of trade agreements. The global coordination mechanism should be tasked with monitoring potential conflicts of interest in WHO and United Nations policy-making on noncommunicable diseases, with particular attention to the potential influence of major producers of pharmaceuticals, foods and beverages.

The representative of STICHTING HEALTH ACTION INTERNATIONAL, speaking at the invitation of the CHAIRMAN, said that progress would need to be accelerated considerably in order to reduce the noncommunicable disease burden by one third by 2030. The lack of baseline data for seven of the nine voluntary global targets revealed an urgent need to reform the measurement system for tracking progress. Governments should prioritize policies and strategies for improving access to medicines, including through the use of trade-related aspects of intellectual property rights (TRIPS) flexibilities. More consideration should be given to cancer in the revision of Appendix 3 of the global action plan.

The representative of the SECRETARIAT of the WHO FRAMEWORK CONVENTION ON TOBACCO CONTROL said that the Convention Secretariat was committed to supporting States parties in the implementation of the WHO Framework Convention on Tobacco Control and to coordinating and leading the global response to achieve the tobacco control-related target under the Sustainable Development Goals. The Convention Secretariat was thus also engaged in the fight against noncommunicable diseases, especially in the light of a decision in 2014 by the Conference of the Parties to the Convention to strengthen its contributions towards the achievement of voluntary global target 5 under the global action plan, which called for a 30% relative reduction in prevalence of tobacco use by 2025. Although 35 countries were on track to achieve that target, most would not do so unless they fully implemented the Convention. She called for the inclusion of the relevant decisions of the Conference of the Parties in WHO's report to the United Nations General Assembly on progress achieved in the implementation of the 2011 Political Declaration and the 2014 outcome document, as outlined in Annex 7 to document A69/10. She urged all States to become parties to the Convention and all current parties to ratify the Protocol to Eliminate Illicit Trade in Tobacco Products.

The ASSISTANT DIRECTOR-GENERAL (Noncommunicable Diseases and Mental Health) noted that, although much work remained to be done and progress had been uneven among Member States, headway had been made since 2011 towards building a global architecture for noncommunicable disease control, with efforts being undertaken not only by WHO but by the entire world. As a symbol of confidence and trust in WHO's leadership, the United Nations Economic and Social Council had decided to extend the mandate of the United Nations Inter-agency Task Force on the Prevention and Control of Non-communicable Diseases to include the new targets related to noncommunicable diseases included in the 2030 Agenda for Sustainable Development. The relevant resolution had been proposed to the United Nations Economic and Social Council by the Government of the Russian Federation and was expected to be adopted on 2 June 2016. A meeting to be held in Shanghai, China, in November 2016 would examine how health promotion could accelerate progress in achieving the specific targets of the Sustainable Development Goals.

The adoption of the framework of engagement with non-State actors would also help to accelerate work on noncommunicable diseases. The Secretariat was well aware of the potential difficulties of working with the private sector and would certainly never accept money from any business that made products that were harmful to health. However, if the private sector changed its strategies and began producing more healthy foods, then it might be advantageous to enter into dialogue with private-sector actors. Indeed, the Organization had a responsibility to encourage the production of healthy foods. Nongovernmental organizations played a crucial role in promoting lifestyles and could also play a valuable "watchdog" role at the country level, bringing gaps to the Organization's attention and thereby enabling it to better target its efforts. The Secretariat would continue to support Member States in implementing the four time-bound commitments for 2015 and 2016. The Secretariat was grateful to Member States for the input received in the current discussion, which would be helpful to it in preparing for the 2018 High-level Meeting.

The CHAIRMAN said that he took it that the Committee wished to approve the draft resolution with the amendments proposed by the representative of Monaco.

The draft resolution, as amended, was approved.¹

Strengthening synergies between the World Health Assembly and the Conference of the Parties to the WHO Framework Convention on Tobacco Control: Item 12.5 of the agenda (documents A69/11 and A69/11 Add.1)

The CHAIRMAN drew attention to the report contained in document A69/11, noting that it contained a draft decision proposed by the Secretariat; the financial and administrative implications of the decision for the Secretariat were contained in document A69/11 Add.1.

The representative of NORWAY said that, while he fully endorsed the objective behind the proposal to strengthen synergies between the Health Assembly and the Conference of the Parties, the draft decision contained in document A69/11 raised governance issues that merited further consideration. First, the proposal was unclear on who should present a report to the Health Assembly and what it should contain. Second, it was unclear whether the resolutions and decisions alluded to in the decision would relate to implementation of the Convention, which in turn raised the question of whether the Conference of the Parties or the Health Assembly was the body competent to take action relating to implementation. Third, the draft decision could enable WHO Member States that were not parties to the Convention to gain influence over the interpretation of the Convention and its implementation. Issues relating to implementation were the prerogative of the Conference of the Parties, which should be given the opportunity to discuss such issues with the Health Assembly before any decisions were taken.

¹ Transmitted to the Health Assembly in the Committee's fourth report and adopted as resolution WHA69.6.

He therefore proposed two amendments to the draft decision. Paragraph (1) should be replaced by: “to invite the Conference of the Parties to the WHO Framework Convention on Tobacco Control to consider the provision of a report for information to the World Health Assembly on the outcomes of the Conference of the Parties to the WHO Framework Convention on Tobacco Control and the modalities relating to the presentation of such a report, and to consider whether to invite the World Health Assembly to provide a report for information on relevant tobacco-related actions”. Paragraph (2) should be replaced by: “to include a report on the outcome of the seventh session of the Conference of the Parties in the provisional agenda of the Seventieth World Health Assembly as a separate agenda item”.

The representative of PANAMA said that strengthening synergies between the Health Assembly and the Conference of the Parties was crucial to progress in protecting populations from the harm to health caused by tobacco. She supported the decision as amended by the representative of Norway.

The representative of AUSTRALIA said that his Government had consistently called for stronger collaboration between the Convention Secretariat and the broader WHO. It supported the objective of increasing the visibility of the Convention but believed it would be best for the Conference of the Parties to consider appropriate strategies first and then to recommend them to the Health Assembly before the latter agreed to a formal recurring agenda item. He therefore supported the amendments proposed by the representative of Norway.

The representative of THAILAND said that the tobacco industry consistently engaged in seductive marketing tactics and took advantage of loopholes in national and international legislative structures to devise new lines of lucrative, but harmful, products. Having a substantial agenda item on Convention implementation at the Health Assembly every two years would enhance collaboration and commitment to counter such threats. He therefore supported the draft decision without reservations.

The representative of URUGUAY said that collaboration between WHO Secretariat and the Convention Secretariat in the fight against tobacco was essential. Similarly, the Health Assembly would benefit greatly from periodic exchanges of information with the Conference of the Parties. She supported the draft decision with the amendment proposed by the representative of Norway.

The representative of SRI LANKA said that adopting a decision on strengthening synergies between the Health Assembly and the Conference of the Parties was important. He wished to propose, however, that a provision be added to the draft decision calling for the Health Assembly to provide a report for information on its relevant tobacco-related resolutions and decisions to the Conference of the Parties, which would allow for technical and political feedback from the Health Assembly to be passed on effectively to the Conference of the Parties.

The representative of TURKEY said that monitoring and control strategies needed to be developed in order to deal with the tactics of the tobacco industry. A better and more comprehensive documentation system, especially mechanisms to share innovative initiatives, was also needed. Her Government strongly supported the strengthening of synergies between the Health Assembly and the Conference of the Parties, including the suggestion to include the activities undertaken by the Health Assembly on the agenda of sessions of the Conference of the Parties and vice versa. In addition, it was important for the WHO Secretariat to share in-depth scientific knowledge with the Conference of the Parties in order to avoid misconceptions about, for example, electronic cigarettes, which might lead to decisions that increased tobacco use rather than reducing it. She supported the draft decision as amended.

The representative of ICELAND, noting that Iceland had been one of the first signatories to the Convention, endorsed the statement made by the representative of Norway.

The representative of IRAQ said that synergies between the Health Assembly and the Conference of the Parties would help to accelerate the implementation of the Convention. Greater synergy could also enhance the effective application of the MPOWER package.

The representative of KENYA, speaking on behalf of the Member States of the African Region, said that, while the Region appreciated the Convention's prioritization of health over trade, it was also cognizant of viable alternatives to tobacco farming that would go a long way in protecting both health and the environment. Synergistic work between the WHO Secretariat and the Convention Secretariat had helped to advance tobacco control. Synergy between the Health Assembly and the Conference of the Parties would be critical to streamlining efforts to meet the Sustainable Development Goal targets, particularly those relating to prevention and control of noncommunicable diseases. He proposed that paragraph (1) of the draft decision should be amended to read: "to invite the Conference of the Parties to the WHO FCTC to provide a report on the outcome of the seventh Conference of the Parties to the Seventieth World Health Assembly". In addition, "in efforts to promote synergy between the Conference of the Parties and the World Health Assembly" should be added at the end of paragraph (2).

The representative of CANADA said that, in principle, his delegation supported the Secretariat's proposal to include the outcomes of the Conference of the Parties as a stand-alone item on the agenda of the Health Assembly every two years; however, it preferred to postpone a decision on the matter until after it had been discussed by the Conference of the Parties at its seventh session, in November 2016. He would welcome a follow-up discussion at the Seventieth World Health Assembly in 2017. He supported the amendments proposed by the representative of Norway.

The representative of CHINA said that his Government supported all activities aimed at reducing the harm caused by tobacco use, welcomed the proposed information exchange mechanism between the Conference of the Parties and the Health Assembly and was hopeful that optimized cooperation would facilitate further activities on tobacco control. He supported the draft decision.

The representative of BAHRAIN said that his Government remained committed to implementing the Convention and had taken a number of steps to implement it, for instance, by introducing a tax on tobacco. He supported the draft decision.

The representative of the PHILIPPINES said that she supported the proposed actions to strengthen synergies between the Health Assembly and the Conference of the Parties. They would provide a platform for the exchange of information, experiences and good practices. Her delegation also supported the amendments to the draft decision proposed by the representative of Norway.

The representative of the NETHERLANDS, speaking on behalf of the European Union and its Member States, said that the former Yugoslav Republic of Macedonia, Serbia, Albania, Bosnia and Herzegovina, Ukraine and the Republic of Moldova aligned themselves with his statement. He was very much in favour of strengthening synergies between the Health Assembly and the Conference of the Parties; however, it was important to do so in a way that respected the governance arrangements of each body. He therefore supported the draft decision as amended by the representative of Norway.

The representative of FRANCE said that her Government was committed to preventing tobacco use among young people. It had recently introduced neutral packaging for cigarettes, and had ratified the Protocol to Eliminate Illicit Trade in Tobacco Products, which should come into force as quickly as possible. She was in favour of strengthening synergies between the Conference of the Parties and the Health Assembly through mutual exchange of information. Tobacco control policies should be at the heart of the efforts to achieve the Sustainable Development Goals and the fight against noncommunicable diseases.

The representative of the UNITED KINGDOM OF GREAT BRITAIN AND NORTHERN IRELAND said that her Government would do its utmost to support the full implementation of the Convention around the world. She supported the amendments proposed by the representative of Norway, which made clear the role of the Conference of the Parties in determining a way forward for cooperation with the Health Assembly.

The representative of TIMOR-LESTE, noting that his country's strategy on noncommunicable diseases included a target of 30% reduction in tobacco use by 2020, said that his delegation supported the draft decision but wished to propose a modification to the amendment proposed by the representative of Norway to paragraph (1), so that the end of the sentence would read: "... to invite the World Health Assembly to provide a report for information on relevant decisions and resolutions of the World Health Assembly".

The representative of the RUSSIAN FEDERATION said that her Government had adopted stringent legislation, which had helped to reduce tobacco use by 20% since 2014. She supported the Secretariat's proposal for a mechanism for cooperation between the Health Assembly and the Conference of the Parties. She also supported the amendments proposed by Norway to the draft decision.

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

The meeting rose at 19:05.

TWELFTH MEETING

Saturday, 28 May 2016, at 09:35

Chairman: Mr M. BOWLES (Australia)

1. FOURTH REPORT OF COMMITTEE A (document A69/73)

The RAPPORTEUR read out the draft fourth report of Committee A.

The report was adopted.¹

2. NONCOMMUNICABLE DISEASES: Item 12 of the agenda (continued)

Strengthening synergies between the World Health Assembly and the Conference of the Parties to the WHO Framework Convention on Tobacco Control: Item 12.5 of the agenda (documents A69/11 and A69/11 Add.1) (continued from the eleventh meeting)

The representative of AUSTRALIA said that, following informal consultations on amendments to the draft decision, the following text had been agreed on:

The Sixty-ninth World Health Assembly,

Having considered the report on strengthening synergies between the World Health Assembly and the Conference of the Parties to the WHO Framework Convention on Tobacco Control,

DECIDES:

(1) to invite the Conference of the Parties to the WHO Framework Convention on Tobacco Control to consider the provision of a report for information to the World Health Assembly on the outcomes of the Conference of the Parties to the WHO Framework Convention on Tobacco Control, as well as the modalities relating to the presentation of such a report;

(2) to invite the Conference of the Parties to the WHO Framework Convention on Tobacco Control to consider inviting the World Health Assembly to provide a report for information to the Conference of Parties to the WHO Framework Convention on Tobacco Control on resolutions and decisions of the World Health Assembly relevant for tobacco-related actions; and

(3) to include a follow-up item in the provisional agenda of the 70th World Health Assembly.

¹ See page 382.

The representative of VIET NAM said that her Government was taking steps to achieve the target to reduce tobacco consumption included in the Sustainable Development Goals. WHO should support Member States with a view to creating synergies at the country level and to providing assistance to monitor accountability. She welcomed the draft decision.

The representative of SOUTH AFRICA noted the progress made in respect of the WHO Framework Convention on Tobacco Control, which encompassed knowledge sharing and resource mobilization. The Conference of the Parties to the WHO Framework Convention on Tobacco Control played a key role by regularly reviewing the effective implementation of the Convention. She supported the draft decision as amended.

The representative of BRAZIL said that the provisions of the Convention had been incorporated into a national action plan against noncommunicable chronic diseases in Brazil where the introduction of tobacco control measures had led to a marked decline in the prevalence of tobacco consumption. The Convention had enhanced the exchange of experiences and lessons learned among countries and the process should be further supported. Multisectoral coordination was also vital to address tobacco control. She supported the draft decision, as amended.

The representative of NEW ZEALAND supported the draft decision, as amended.

The representative of MALDIVES expressed full support for the draft decision, as amended.

The representative of the REPUBLIC OF KOREA said that the Republic of Korea had adopted various measures to prevent tobacco consumption and to combat its negative effects. The inclusion of tobacco control in the goals of the 2030 Agenda for Sustainable Development was timely and relevant, and would contribute to the prevention of noncommunicable diseases. The establishment of a mechanism to promote regular information sharing between the WHO Secretariat and the Convention Secretariat would inform and benefit national policy-making.

The representative of MALAYSIA said that incorporating the Convention into the Health Assembly agenda was essential in order to boost support from other international organizations, such as the World Trade Organization and the International Organization for Standardization, and to respond to the globalization of the tobacco epidemic.

The observer of CHINESE TAIPEI said that tobacco control legislation in Chinese Taipei had been harmonized as far as possible with the WHO Framework Convention on Tobacco Control and action had been taken to curb tobacco consumption by expanding prohibitions on smoking and establishing support services for persons giving up smoking. Efforts to increase taxation on tobacco products would continue despite resistance from the tobacco industry. She welcomed the strengthening of mechanisms to support implementation of the Convention and supported the draft decision.

The representative of the INTERNATIONAL UNION AGAINST TUBERCULOSIS AND LUNG DISEASE, speaking at the invitation of the CHAIRMAN, welcomed the strengthening of synergies between the Health Assembly and the Conference of the Parties to the WHO Framework Convention on Tobacco Control, as increased communication between the two bodies would facilitate and expedite progress towards achieving Sustainable Development Goal 3. Lessons learned as a result of that cooperation would be invaluable for swiftly and effectively reducing other noncommunicable disease risk factors. Noting that 63% of premature deaths each year were caused by noncommunicable diseases, she urged WHO to capitalize on the resources offered by tobacco control experts to curb associated global epidemics.

The representative of the WORLD MEDICAL ASSOCIATION, INC., speaking at the invitation of the CHAIRMAN, said that the Association was committed to mobilizing health professionals to implement the WHO Framework Convention on Tobacco Control and supported national medical associations in encouraging their governments to ratify and give effect to the Convention. He urged governments to introduce regulations in accordance with the Convention and requested that WHO should take a leading role in countering the undue influence of the tobacco industry by developing new trade agreements. He welcomed the establishment of tobacco industry monitoring mechanisms and emphasized the vital role of physicians in public health education.

The representative of the FRAMEWORK CONVENTION ALLIANCE ON TOBACCO CONTROL, speaking at the invitation of the CHAIRMAN and also on behalf of the Union for International Cancer Control and Alzheimer's Disease International, supported the view that the governing bodies of WHO and the WHO Framework Convention on Tobacco Control should periodically exchange information. The Conference of the Parties to the Convention would regularly review progress towards the global voluntary target on the prevalence of tobacco use and develop further actions to reach the target.

The Head of the SECRETARIAT of the WHO FRAMEWORK CONVENTION ON TOBACCO CONTROL said that tobacco consumption continued to be a worldwide epidemic that required an effective international response and a multisectoral approach; the public health outcomes would depend on health sector leadership. The inclusion of the Convention on the Health Assembly agenda raised the profile of the Convention. To ensure its recognition as a legally-binding instrument, awareness should be fostered by creating a mechanism for the exchange of information between the Health Assembly and the Conference of the Parties. She invited Member States to attend the forthcoming session of the Conference of the Parties and to ensure implementation of the Convention.

The ASSISTANT DIRECTOR-GENERAL (Noncommunicable Diseases and Mental Health) thanked all Member States for their participation in the timely discussion leading to the draft decision on the priority item of tobacco control.

The CHAIRMAN took it that the Committee wished to approve the draft decision contained in document A69/11, as amended.

The draft decision, as amended, was approved.¹

Addressing the challenges of the United Nations Decade of Action for Road Safety (2011–2020): outcome of the second Global High-level Conference on Road Safety – Time for Results:
Item 12.7 of the agenda (document A69/13)

The CHAIRMAN drew attention to a draft resolution proposed by the delegations of Australia, Brazil, the Dominican Republic and Guatemala, which read:

The Sixty-ninth World Health Assembly,
(PP1) Having considered the report on addressing the challenges of the United Nations Decade of Action for Road Safety (2011–2020): outcome of the Second Global High-level Conference on Road Safety – Time for Results;²

¹ Transmitted to the Health Assembly in the Committee's fifth report and adopted as decision WHA69(13).

² Document A69/13.

(PP2) Recognizing that road traffic injuries constitute a public health problem and a leading cause of death and injury around the world, with significant health and socioeconomic costs;

(PP3) Recalling resolution WHA57.10 (2004) on road safety and health, which accepted the invitation of the United Nations General Assembly for WHO to act as a coordinator on road safety issues within the United Nations system, and resolution WHA60.22 (2007) on health systems: emergency care systems;

(PP4) Welcoming the proclamation of the Decade of Action for Road Safety, in United Nations General Assembly resolution 64/255 (2010) on improving global road safety, and the reiteration of the General Assembly's invitation to United Nations Member States to play a leading role in implementing the activities of the Decade of Action in resolution 68/269 (2014);

(PP5) Commending the work of the WHO Secretariat in coordinating global road safety initiatives through the United Nations Road Safety Collaboration, in providing secretariat support to the Decade of Action, and in leading efforts to raise awareness, increase capacity and provide technical support to Member States;

(PP6) Further recognizing that a multisectoral and intersectoral approach is needed to reduce the burden of road traffic deaths and injuries and that evidence-based interventions exist; that the health sector has a significant role to play in improving road user behaviour, promotion of health, communication and education regarding preventive measures, data collection and post-crash responses; and that a "safe system approach" involves several other sectors for vehicle safety regulations, enforcement, road infrastructure, and road safety education and management;

(PP7) Reaffirming that providing basic conditions and services to address road safety is primarily a responsibility of governments, while recognizing nonetheless that there is a shared responsibility to move towards a world free from road traffic fatalities and serious injuries, and that addressing road safety demands multistakeholder collaboration among the public and private sectors, academia, professional organizations, nongovernmental organizations and the media;

(PP8) Welcoming the large number of activities since 2004 that have contributed to reducing the number of deaths and serious injuries due to road traffic crashes, in particular: the publication of several manuals for decision-makers and practitioners; the periodic publication of global status reports on road safety; the proclamation of the Decade of Action for Road Safety 2011–2020; the holding of three global United Nations road safety weeks; the outcome of the First Global Ministerial Conference on Road Safety (Moscow, 2009); the inclusion of targets 3.6 and 11.2 in the 2030 Agenda for Sustainable Development; and the outcome of the Second Global High-level Conference on Road Safety (Brasília, 18–19 November 2015),

(OP) 1. ENDORSES the Brasília Declaration on Road Safety, the outcome document of the Second Global High-level Conference on Road Safety;

(OP) 2. CONSIDERS that all sectors, including the public health sector, should intensify their efforts to meet the international road safety targets set by the Decade of Action and the 2030 Agenda for Sustainable Development and accelerate their activities, including the collection of appropriate data on road traffic deaths and injuries by Member States within existing structures for use in prevention and education, the strengthening of emergency care systems and response infrastructure (including pre-hospital and facility-based trauma care), as well as comprehensive support to victims and their families and rehabilitation support services for those injured in road traffic crashes;

(OP) 3. URGES Member States:¹

- (1) to implement the Brasília Declaration on Road Safety;
- (2) to renew their commitment to the Decade of Action for Road Safety 2011–2020 and to implement the Global Plan for the Decade of Action for Road Safety 2011–2020;
- (3) to act upon the results, conclusions and recommendations of WHO's global status reports on road safety;
- (4) to develop and implement, if they have not already done so, a national strategy and appropriate action plans that pay particular attention to vulnerable road users with a special focus on children, youth, older persons and persons with disabilities, and for which commensurate resources are available;
- (5) to adopt and enforce laws on the key risk factors, including speeding, drinking alcohol and driving, and failure to use motorcycle helmets, seat-belts and child restraints, and to consider implementing appropriate, effective and evidence-based legislation on other risk factors related to distracted or impaired driving;
- (6) to improve the quality of road safety data by strengthening efforts to collect appropriate, reliable, and comparable data on road traffic injury prevention and management, including the impact of road traffic crashes on health and development as well as the economic impacts and cost-effectiveness of interventions;
- (7) to implement a single emergency national access number and improve prevention and emergency medicine training programmes for health sector professionals in respect of road traffic crashes and trauma;

(OP) 4. REQUESTS the Director-General:

- (1) to continue to facilitate, with the full participation of Member States and in collaboration with organizations in the United Nations system (including the United Nations regional commissions), through the existing mechanisms (including the United Nations Road Safety Collaboration), a transparent, sustainable and participatory process with all stakeholders, in order to assist interested countries in developing voluntary global performance targets on key risk factors and service delivery mechanisms to reduce road traffic fatalities and injuries, in the context of the process leading to the definition and use of indicators for the road safety-related targets in the 2030 Agenda for Sustainable Development and the Global Plan for the Decade of Action for Road Safety 2011–2020;
- (2) to provide support to Member States in implementing evidence-based policies and practices to improve road safety and to mitigate and reduce road traffic injuries in line with the Global Plan for the Decade of Action for Road Safety 2011–2020 and the 2030 Agenda for Sustainable Development;
- (3) to provide technical support for the strengthening of pre-hospital care, including emergency health services and the immediate post-crash response, hospital and ambulatory guidelines for trauma care, and rehabilitation services, capacity-building and improvement of timely access to integral health care;
- (4) to maintain and strengthen evidence-based approaches to raising awareness for prevention and mitigation of road traffic injuries and to facilitate such work globally, regionally and nationally;
- (5) to continue, in collaboration with the United Nations regional commissions, as well as other relevant United Nations agencies, the activities aimed at supporting the implementation of the objectives and goals of the Decade of Action for Road Safety and the road safety-related targets in the 2030 Agenda for Sustainable Development, while ensuring system-wide coherence;

¹ And, where applicable, regional economic integration organizations.

- (6) to continue to monitor, through its global status reports, progress towards the achievement of the goals of the Decade of Action for Road Safety 2011–2020;
- (7) to facilitate, in collaboration with the United Nations regional commissions, the organization of activities during 2017 for the fourth United Nations Global Road Safety Week;
- (8) to report on progress made in implementing this resolution to the Seventieth World Health Assembly.

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

Resolution: Addressing the challenges of the United Nations Decade of Action for Road Safety (2011–2020): outcome of the Second High-level Conference on Road Safety – Time for Results			
A. Link to the general programme of work and the programme budget			
1. Please indicate to which impact and outcome in the Twelfth General Programme of Work, 2014–2019 and which output in the Programme budget 2016–2017 this draft resolution will contribute if adopted. Impacts: reduce premature mortality from noncommunicable diseases; and prevention of death, illness and disability arising from emergencies. Outcome 2.3, output 2.3.1.			
2. If there is no link to the results as indicated in the Twelfth General Programme of Work, 2014–2019 and the Programme budget 2016–2017, please provide a justification for giving consideration to the draft resolution. Not applicable.			
3. What is the proposed timeline for implementation of this resolution? A process to set targets and indicators will be developed during the biennium 2016–2017 and other activities referred to in the resolution will be carried out during the bienniums 2016–2017 and 2018–2019. <i>If the timeline stretches to future programme budgets, please ensure that further information is provided in the costing section.</i>			
B. Budgetary implications of implementation of the resolution			
1. Current biennium: estimated budgetary requirements, in US\$ million			
Level	Staff	Activities	Total
Country offices	1.20	1.30	2.50
Regional offices	1.00	0.50	1.50
Headquarters	2.00	1.30	3.30
Total	4.20	3.10	7.30
1(a) Is the estimated budget requirement in respect of implementation of the resolution fully included within the current programme budget? (Yes/No) Yes			

1(b) Financing implications for the budget in the current biennium:

- **How much is financed in the current biennium?** US\$ 5.84 million
- **What are the gaps?** US\$ 1.46 million
- **What action is proposed to close these gaps?**
The gap will be closed through resource mobilization and voluntary contributions.

2. Next biennium: estimated budgetary requirements, in US\$ million

Level	Staff	Activities	Total
Country offices	1.30	1.50	2.80
Regional offices	1.10	0.75	1.85
Headquarters	2.20	1.20	3.40
Total	4.60	3.45	8.05

2(a) Financing implications for the budget in the next biennium:

- **How much is currently financed in the next biennium?** US\$ 1.81 million
- **What are the financing gaps?** US\$ 6.24 million
- **What action is proposed to close these gaps?**
The gap will be closed through the financing dialogue and extrabudgetary funding.

The representative of THAILAND encouraged Member States to accelerate actions to reduce the level of road traffic fatalities by 2020 and requested that WHO should provide monitoring and annual forecasts to assist them in that task. Reducing road traffic fatalities by 50% was an ambitious target for many developing countries, given the current increase in the number of fatalities in more than half of low- and middle-income countries. In the light of evidence that showed that the average consumption of alcohol in society had a strong association with road traffic injuries and deaths, it was timely to consider the introduction of a supranational tool to control alcohol along the lines of the WHO Framework Convention on Tobacco Control.

The representative of AUSTRALIA thanked the Secretariat for the report and said that Australia was proud to sponsor the draft resolution.

The representative of ARGENTINA welcomed the report by the Secretariat. It was essential to prioritize the development of international public policies and to scale up activities undertaken within the framework of the Decade of Action for Road Safety. The Health Assembly constituted an excellent forum to reaffirm commitments and propose new strategies in that regard.

The representative of GUATEMALA said that his Government, as one of the draft resolution's sponsors, wished to reiterate its commitment to continued efforts towards achieving its objectives.

The representative of SENEGAL, noting the magnitude and severity of road traffic accidents, said that the wider social and economic costs should be taken into account, in addition to the immediate consequences of deaths and injuries. Taking a multisectoral approach, his country had adopted practical measures to address the issue. He supported the draft resolution and encouraged Member States to adopt the measures outlined in the document.

The representative of the UNITED STATES OF AMERICA said that the health sector had a key leadership role to play to reach the goals of the Decade of Action for Road Safety and of the 2030 Agenda for Sustainable Development. Noting that preventing road traffic injuries and deaths demanded a multisectoral approach, he emphasized the importance of building capacity in data collection and of the systematic use of data to prevent road traffic injuries and better respond to their impact on families and communities. He supported the draft resolution.

The representative of the DEMOCRATIC REPUBLIC OF THE CONGO, speaking on behalf of the Member States of the African Region, welcomed the Second Global High-level Conference on Road Safety held in Brazil and its outcome document, the Brasília Declaration. Deaths and injuries resulting from road traffic accidents were not considered as a public health priority in most African countries, which faced many challenges and gaps in legislation and services. The Member States of the African Region thus proposed: encouraging countries to draw up multisectoral plans to address health problems caused by road accidents; encouraging countries to invest in awareness-raising and training on road traffic accident prevention; working with insurance companies to improve prevention and insurance cover for road traffic accident victims; encouraging Member States, WHO and its technical and financial partners to help countries establish specialized units to deal with disabilities associated with road traffic accident injuries, including mobile units; and setting up mechanisms to ensure safe transport and the referral of cases to specialized services.

The representative of CHINA said that his Government was in favour of improving the quality of systematic and comprehensive data collection to increase data reliability and endorsed WHO's further efforts to define road traffic death and injury indicators. More technical support in data standardization, to ensure that Member States collected data following international standards, would be appreciated. Traffic accidents involving electric bicycles were on the rise in developing countries, and electric bicycle users were both vulnerable road users and a threat to the safety of other vulnerable road users. Therefore, he proposed that electric bicycle users should be included in the list of vulnerable road users and that relevant legislation should apply to them.

The representative of BRAZIL welcomed the adoption by the United Nations General Assembly in 2016 of a resolution on improving global road safety, which endorsed the Brasília Declaration. The resolution reaffirmed the global support and commitment of countries to reducing traffic-related deaths and injuries, and ratified the traffic safety targets established in the Sustainable Development Goals. It also called on the United Nations Secretary-General to consider establishing a road safety fund to support the implementation of the Global Plan for the Decade of Action for Road Safety 2011–2020 and the relevant Sustainable Development Goals. Brazil had therefore sponsored the draft resolution. She called on Member States to strengthen or establish national plans to address the risk factors and support more vulnerable road users.

The representative of JAPAN expressed appreciation for WHO's leadership in addressing the problem of global traffic injuries. He emphasized that road traffic deaths and injuries were preventable and that some prevention measures such as the legal enforcement of the use of seat belts and child restraints in cars and motorcycle helmets were cost effective compared with other life-saving interventions. His Government fully supported the draft resolution.

The representative of the UNITED REPUBLIC OF TANZANIA noted with appreciation that her country had been selected to participate in the Bloomberg Initiative for Global Road Safety. Her Government called on WHO to continue mobilizing resources for road safety initiatives and underscored that efforts must include improving post-crash care. Her Government continued to be committed to initiatives to reduce road traffic injuries in the framework of the Decade of Action for Road Safety. She expressed support for the draft resolution.

The representative of TIMOR-LESTE said that, in order to combat the high road-traffic death rate in Timor-Leste, his Government, with support from the Regional Office for South-East Asia, had taken several measures in line with the Decade of Action, including the adoption of legislation on road safety. He fully supported the draft resolution.

The representative of ECUADOR said that she shared the views expressed by previous speakers and wished to add Ecuador to the list of sponsors of the draft resolution.

The representative of VIET NAM expressed support for the Brasília Declaration and the draft resolution. With respect to subparagraph 3(6) of the draft resolution, he said that the quality of road safety data would be improved by ensuring that it was updated. With respect to paragraph 4, he said that the Director-General could play an important role by advocating at the global level a multisectoral and intersectoral approach to road safety.

The observer of CHINESE TAIPEI said that road traffic injuries were a major cause of death in Chinese Taipei, due to high motorcycle use. The Government was making every effort to adopt, amend and promote road safety regulations and legislation and to raise public awareness. Amendments to regulations included the mandatory wearing of motorcycle helmets, which had led to a 50% reduction in road traffic deaths. Chinese Taipei was willing to share with its partners information on its success with respect to legislative measures to promote road safety.

The representative of MEDICUS MUNDI INTERNATIONAL – INTERNATIONAL ORGANISATION FOR COOPERATION IN HEALTH CARE, speaking at the invitation of the CHAIRMAN, said that the built environment must be reclaimed for pedestrians, cyclists and public transport. WHO must show coherence between the issues of air pollution and road safety and call upon Member States to regulate the heavy-polluting automobile industry. He urged Member States to take a broader view on the health and environmental benefits of a non-motorized approach and to share best practices on urban design and policy, which should act as a stepping stone to a full transition to a non-motorized future.

The ASSISTANT DIRECTOR-GENERAL (Noncommunicable Diseases and Mental Health) said that the report by the Secretariat highlighted that bolder measures were needed to reduce the increasing number of road traffic deaths. He thanked the Government of Brazil for having hosted the second Global High-level Conference on Road Safety and for having facilitated the process for elaboration of the draft resolution; he also thanked Member States for their active support. In follow-up, the Secretariat would facilitate attainment of target 3.6 of the Sustainable Development Goals. Furthermore, it would continue to support countries in implementing best practices in road safety and trauma care. It also intended to finalize a technical package on road safety by the end of 2016, and would prepare and publish a fourth global status report on road safety in early 2019, ahead of the high-level political forum on sustainable development to be held in mid-2019.

The draft resolution was approved.¹

Maternal, infant and young child nutrition: Item 12.1 of the agenda (documents A69/7, A69/7 Add 1 and A69/7 Add.2) (continued from the second meeting, section 1)

The CHAIRMAN recalled that a drafting group had been established to consider the two draft resolutions under item 12.1. He drew attention to a revised draft resolution on the Decade of Action on

¹ Transmitted to the Health Assembly in the Committee's fifth report and adopted as resolution WHA69.7.

Nutrition, proposed by the delegations of Chad, Ecuador, Haiti, New Zealand, Panama and Peru. The text, which reflected the discussions in the drafting group, read:

The Sixty-ninth World Health Assembly,

(PP1) Having considered the report on maternal, infant and young child nutrition;¹

(PP2) Recalling resolution WHA68.19 (2015) on the outcome of the Second International Conference on Nutrition, endorsing the Rome Declaration on Nutrition as well as the Framework for Action;

(PP3) Reaffirming the commitments to implement relevant international targets and action plans, including the WHO 2025 Global Nutrition Targets and the WHO's global action plan for the prevention and control of noncommunicable diseases 2013–2020;

(PP3bis) Recalling resolution A67.15 (2014) in which the Member States approved the comprehensive implementation plan on maternal, infant and young child nutrition to assess progress towards reaching the goals;

(PP4) Recalling United Nations General Assembly resolution 70/1 of 25 September 2015, entitled "Transforming our world: the 2030 Agenda for Sustainable Development", acknowledging the integrated dimension of the goals and recognizing that to end all forms of malnutrition and address nutritional needs throughout the life course, it is necessary to give universal access to safe and nutritious food that is sustainably produced, and to ensure universal coverage of essential nutrition actions;

(PP5) Recalling that the Sustainable Development Goals and targets are integrated and indivisible and balance the three dimensions of sustainable development, and acknowledging the importance of reaching Sustainable Development Goal 2, which aims to end hunger, achieve food security and improved nutrition and promote sustainable agriculture, as well as the interlinked targets of other Goals;

(PP6) Welcoming United Nations General Assembly resolution 70/259 of 1 April 2016, entitled "United Nations Decade of Action on Nutrition (2016–2025)"; which calls upon FAO and WHO to lead the implementation of the United Nations Decade of Action on Nutrition (2016–2025), in collaboration with the WFP, IFAD and UNICEF, and to identify and develop a work programme based on the Rome Declaration on Nutrition and its Framework for Action, along with its means of implementation for 2016–2025, using coordination mechanisms such as the Standing Committee on Nutrition and multistakeholder platforms such as the Committee on World Food Security, in line with its mandate, and in consultation with other international and regional organizations, platforms and movements such as the Scaling up Nutrition;

(PP7) Reaffirming the commitment to eradicate hunger and prevent all forms of malnutrition worldwide, particularly undernourishment, stunting, wasting, underweight and overweight in children under 5 years of age and anaemia in women and children, among other micronutrient deficiencies; as well as to halt the rising trends in overweight and obesity and reduce the burden of diet-related noncommunicable diseases in all age groups;

(PP8) Recalling resolution WHA65.6 (2012), endorsing the comprehensive implementation plan on maternal, infant and young child nutrition;

(PP9) Expressing concern that nearly two in every three infants under 6 months are not exclusively breastfed; that fewer than one in five infants are breastfed for 12 months in high-income countries; and that only two in every three children between 6 months and 2 years of age receive any breast-milk in low- and middle-income countries;

(PP10) Expressing concern that only 49% of countries have adequate nutrition data to assess progress towards the global nutrition targets,

¹ Document A69/7.

(OP1) CALLS UPON all relevant United Nations funds, programmes, specialized agencies, civil society and other stakeholders:

- (1) to work collectively across sectors and constituencies to guide, support, and implement nutrition policies, programmes, and plans under the umbrella of the United Nations Decade of Action on Nutrition (2016–2025);
- (2) to support mechanisms for monitoring and reporting of the commitments;

(OP2) URGES Member States:

- (1) to develop and/or implement strategies on maternal, infant and young child nutrition that comprehensively respond to nutrition challenges, span different sectors and include robust and disaggregated monitoring and evaluation;
- (2) to consider developing, when appropriate, policies and financial commitments that are specific, measurable, achievable, relevant and time-bound (SMART) in respect of the Rome Declaration on Nutrition and the voluntary options contained in the Framework for Action of the Second International Conference on Nutrition as well as the Comprehensive Implementation Plan on Maternal, Infant and Young Child Nutrition;
- (2bis) to consider the definition of national targets based on global targets adapted to national priorities and specific parameters;
- (2ter) to consider allocating adequate funding taking into account the local context;
- (3) to provide information on a voluntary basis on their efforts to implement the commitments of the Rome Declaration on nutrition through a set of voluntary policy options within the Framework for Action including their policy and investments for effective interventions to improve people's diets and nutrition, including in emergency situations;

(OP3) REQUESTS the Director-General:

- (1) to work with the Director-General of FAO:
 - (a) to support Member States, upon request, in developing, strengthening and implementing their policies, programmes and plans to address the multiple challenges of malnutrition, and convene periodic meetings of inclusive nature to share best practices, including consideration of commitments that are specific, measurable, achievable, relevant and time-bound within the framework of the Decade of Action on Nutrition (2016–2025);
 - (b) to maintain an open access database of commitments for public accountability and include an analysis of the commitments made in the biennial reports on implementation of the outcome document of the Second International Conference on Nutrition and the Framework for Action;
- (2) to continue to provide technical support to Member States for the implementation of the Decade of Action on Nutrition and of the Comprehensive Implementation Plan on Maternal, Infant and Young Child Nutrition;
- (3) to continue supporting the Breastfeeding Advocacy Initiative to increase political commitment to and investment in breastfeeding as the cornerstone of child nutrition, health and development;
- (4) to support Member States in strengthening the nutrition component of national information systems including data collection and analysis for evidence-informed policy decision-making.

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

Resolution: Decade of Action on Nutrition from 2016 to 2025			
A. Link to the general programme of work and the programme budget			
1. Please indicate to which impact and outcome in the Twelfth General Programme of Work, 2014–2019 and which output in the Programme budget 2016–2017 this draft resolution will contribute if adopted. General Programme of Work outcome 2.5 and Programme budget output 2.5.1.			
2. If there is no link to the results as indicated in the Twelfth General Programme of Work, 2014–2019 and the Programme budget 2016–2017, please provide a justification for giving consideration to the draft resolution. Not applicable.			
3. What is the proposed timeline for implementation of this resolution? Implementing the resolution will require long-term commitment from Member States. The Secretariat can immediately implement tasks during the biennium 2016–2017 and report to the Health Assembly in 2018 and 2020. <i>If the timeline stretches to future programme budgets, please ensure that further information is provided in the costing section.</i>			
B. Budgetary implications of implementation of the resolution			
1. Current biennium: estimated budgetary requirements, in US\$ million			
Level	Staff	Activities	Total
Country offices	0.360	1.200	1.560
Regional offices	0.660	0.300	0.960
Headquarters	1.334	0.800	2.134
Total	2.354	2.300	4.654
1(a) Is the estimated budget requirement in respect of implementation of the resolution fully included within the current programme budget? (Yes/No) Yes.			
1(b) Financing implications for the budget in the current biennium: – How much is financed in the current biennium? US\$ 3.014 million – What are the gaps? US\$ 1.640 million – What action is proposed to close these gaps? For staff: synergies with other programmes and discussions with regional offices and with donors at the country level. For meetings: discussions with FAO on cost-sharing and jointly approach donors.			

2. Next biennium: estimated budgetary requirements, in US\$ million			
Level	Staff	Activities	Total
Country offices	0.360	1.200	1.560
Regional offices	0.660	0.300	0.960
Headquarters	1.334	0.200	1.534
Total	2.354	1.700	4.054
2(a) Financing implications for the budget in the next biennium: <ul style="list-style-type: none"> – How much is currently financed in the next biennium? US\$ 2.514 million – What are the financing gaps? US\$ 1.540 million – What action is proposed to close these gaps? For staff: synergies with other programmes and discussions with regional offices and with donors at the country level. For meetings: discussions with FAO on cost-sharing and jointly approach donors. 			

The CHAIRMAN also drew attention to a revised draft resolution on ending inappropriate promotion of foods for infants and young children, proposed following discussions in the drafting group by the delegations of Chad, Ecuador, Kenya, Mexico, Mozambique, Niger, Norway, Panama, Sudan, Switzerland, Thailand, and Zimbabwe, which read:

The Sixty-ninth World Health Assembly,

(PP1) Recalling resolutions WHA33.32 (1980), WHA34.22 (1981), WHA35.26 (1982), WHA37.30 (1984), WHA39.28 (1986), WHA41.11 (1988), WHA43.3 (1990), WHA45.34 (1992), WHA46.7 (1993), WHA47.5 (1994), WHA49.15 (1996), WHA54.2 (2001), WHA55.25 (2002), WHA58.32 (2005), WHA59.21 (2006), WHA61.20 (2008) and WHA63.23(2010) on infant and young child nutrition, appropriate feeding practices and related questions;

(PP2) Further recalling resolution WHA65.6 (2012) on maternal, infant and young child nutrition, in which the Health Assembly requested the Director-General to provide guidance on the inappropriate promotion of foods for infants and young children cited in resolution WHA63.23;

(PP3) Convinced that guidance on ending the inappropriate promotion of foods for infants and young children is needed for Member States, the private sector, health systems, civil society and international organizations;

(PP4) Reaffirming the need to promote exclusive breastfeeding practices in the first 6 months of life, and the continuation of breastfeeding up to 2 years and beyond, and recognizing the need to promote optimal complementary feeding practices for children from ages 6–36 months based on WHO's and FAO's dietary guidelines¹ and in accordance with national dietary guidelines;

(PP5) Recognizing that the Codex Alimentarius Commission is an intergovernmental body which is the principal organ of the joint FAO/WHO food standards programme and that it is the appropriate body for establishing the international standards on food products, and that reviews of Codex standards and guidelines should give full consideration to WHO guidelines

¹ PAHO and WHO. Guiding principles for complementary feeding of the breastfed child, 2003; WHO. Guiding principles for feeding non breast-fed children 6–24 month of age, 2005.

and recommendations, including the international code of marketing of breast milk substitutes and relevant WHA resolutions,

(OP1) WELCOMES with appreciation the technical guidance on ending the inappropriate promotion of foods for infants and young children;

(OP2) URGES Member States^{1,2,3} in accordance with national context;

(1) to take all necessary measures in the interest of public health to end the inappropriate promotion of foods for infants and young children, including in particular implementation of the guidance recommendations while taking into account existing legislation and policies, as well as international obligations;

(2) to establish a system for monitoring, and evaluation of the implementation of the guidance recommendations;

(3) to end inappropriate promotion of food for infants and young children, and to promote policy, social and economic environments that enable parents and caregivers to make well informed infant and young child feeding decisions and further support appropriate feeding practices by improving health and nutrition literacy;

(4) to continue to implement the International Code of Marketing of Breast-milk Substitutes and WHO set of recommendations on the marketing of foods and non-alcoholic beverages to children;

(OP3) CALLS UPON manufacturers and distributors of foods for infants and young children to end all forms of inappropriate promotion, as set forth in the guidance recommendations;

(OP4) CALLS UPON health care professionals to fulfil their essential role in providing parents and other caregivers with information and support on optimal infant and young child feeding practices and to implement the guidance recommendations;

(OP5) URGES the media and creative industries to ensure that their activities across all communication channels and media outlets, in all settings and using all marketing techniques, are carried out in accordance with the guidance recommendations on ending the inappropriate promotion of foods for infants and young children;

(OP6) CALLS UPON civil society to support ending inappropriate promotion of foods for infants and young children, including activities to advocate for, and monitor Member States progress towards the guidance's aim;

(OP7) REQUESTS the Director-General:

(1) to provide technical support to Member States in implementing the guidance recommendations on ending the inappropriate promotion of foods for infants and young children and in monitoring and evaluating its implementation;

(2) to review national experiences with implementing the guidance recommendations in order to build the evidence on its effectiveness and consider changes, if required;

(3) to strengthen international cooperation with relevant United Nations funds, programmes and specialized agencies and other international organizations, in promoting

¹ And, where applicable, regional economic integration organizations.

² Taking into account the context of federated states.

³ Member States could take additional actions to end inappropriate promotion of foods for infants and young children.

national action to end the inappropriate promotion of foods for infants and young children taking into consideration the WHO guidance recommendations;

(4) to report on implementation of the guidance recommendations on ending the inappropriate promotion of foods for infants and young children as part of the report on progress in implementing the Comprehensive Implementation Plan on maternal, infant and young child nutrition to the Seventy-first and Seventy-third World Health Assemblies in 2018 and 2020.

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

Resolution: Maternal, infant and young child nutrition			
A. Link to the general programme of work and the programme budget			
1. Please indicate to which impact and outcome in the Twelfth General Programme of Work, 2014–2019 and which output in the Programme budget 2016–2017 this draft resolution will contribute if adopted. General Programme of Work outcome 2.5 and Programme budget output 2.5.2.			
2. If there is no link to the results as indicated in the Twelfth General Programme of Work, 2014–2019 and the Programme budget 2016–2017, please provide a justification for giving consideration to the draft resolution. Not applicable.			
3. What is the proposed timeline for implementation of this resolution? Implementing the resolution will require long-term commitment from Member States. The Secretariat can immediately implement tasks during the biennium 2016–2017 and report to the Health Assembly in 2018 and 2020. <i>If the timeline stretches to future programme budgets, please ensure that further information is provided in the costing section.</i>			
B. Budgetary implications of implementation of the resolution			
1. Current biennium: estimated budgetary requirements, in US\$ million			
Level	Staff	Activities	Total
Country offices	0.120	0.100	0.220
Regional offices	0.330	0.081	0.411
Headquarters	0.330	0.020	0.350
Total	0.780	0.201	0.981
1(a) Is the estimated budget requirement in respect of implementation of the resolution fully included within the current programme budget? (Yes/No) Yes.			
1(b) Financing implications for the budget in the current biennium: – How much is financed in the current biennium? US\$ 0.89 million			

– **What are the gaps?**

US\$ 0.09 million

– **What action is proposed to close these gaps?**

Synergies with other programmes and discussion with regional offices and with donors at the country level.

2. Next biennium: estimated budgetary requirements, in US\$ million

Level	Staff	Activities	Total
Country offices	0.120	0.100	0.220
Regional offices	0.330	0.081	0.411
Headquarters	0.330	0.020	0.350
Total	0.780	0.201	0.981

2(a) Financing implications for the budget in the next biennium:

– **How much is currently financed in the next biennium?**

US\$ 0.89 million

– **What are the financing gaps?**

US\$ 0.09 million

– **What action is proposed to close these gaps?**

Synergies with other programmes and discussion with regional offices and with donors at the country level. It is assumed that salaries of regional programme managers will continue to be funded by WHO as in the present biennium.

The representative of ECUADOR, speaking in her capacity as the Chairman of the drafting group, said that the group had held three formal meetings and one informal meeting to discuss and agree on the revised wording of the two draft resolutions originally proposed by the delegation of Ecuador on the Decade of Action on Nutrition and on ending inappropriate promotion of foods for infants and young children.

The representative of GUATEMALA said that his country wished to be added to the list of sponsors of the draft resolutions. He reiterated his Government's commitment to such important issues.

The representative of FRANCE expressed support for the draft resolutions.

The representative of BOTSWANA, speaking on behalf of the Member States of the African Region, said that progress in African countries lagged behind global and regional trends in respect of the achievement of maternal, infant and young children nutrition indicators. Gaps still existed in translating into concrete actions the efforts being made by the Member States of the Region to improve maternal, infant and young child nutrition. In particular, those gaps were related to the integration of nutrition-sensitive and nutrition-specific interventions, consensus in the approach to reducing stunting and overweight trends, and the integration of essential nutrition services into primary health care. The Member States of the African Region supported both draft resolutions and wished to be added to the list of sponsors.

The representative of CHAD said that his Government had taken an active part in the discussions and was a sponsor of the draft resolutions. Given the importance of the draft resolutions, he called for their adoption by the Health Assembly.

The representative of JAMAICA said that draft national action plans on preventing and managing child and adolescent obesity, on infant and young child feeding and on food and nutrition security were currently awaiting government approval in Jamaica. Her Government had noted the need for nutrition-specific and nutrition-sensitive investments, and that effective nutrition programmes should be factored into plans for the achievement of universal health coverage. She expressed support for both draft resolutions.

The representative of JAPAN fully supported the draft resolution on ending inappropriate promotion of foods for infants and young children. He was pleased that the relevance of national contexts had been accepted with respect to implementation of the guidance contained in document A69/7 Add.1 and he requested information on the progress made in respect of implementation. Countries' health information systems needed to be strengthened in order to better identify nutrition indicators and integrate data into national health systems. He welcomed the United Nations Decade of Action on Nutrition, the Rome Declaration on Nutrition and the Framework for Action and expected WHO to take a leading role in promoting them. Action taken in that connection should be consistent with WHO's existing guidelines and action plans and should not place an additional burden on Member States with respect to monitoring and data collection.

The representative of SWITZERLAND supported both draft resolutions. She appreciated that they were consistent with existing efforts made by WHO and its Member States, including in respect of the 2030 Agenda for Sustainable Development. The draft resolution on ending inappropriate promotion of foods for infants and young children, which the delegation of Switzerland had sponsored, facilitated progress in promoting healthy foods and diets, which was key to overcoming childhood obesity.

The representative of NORWAY welcomed the agreement reached on the draft resolution on ending inappropriate promotion of foods for infants and young children. It was important for the Health Assembly to take an immediate decision on that issue. He commended WHO for the work it had carried out; the technical guidance provided would be a helpful tool for Member States to end inappropriate marketing practices. Non-State actors must also support implementation of the guidance. He supported the draft resolution on the Decade of Action on Nutrition.

The representative of the UNITED STATES OF AMERICA supported both draft resolutions, which Member States should take appropriate measures to implement. He acknowledged the key role of Codex Alimentarius in setting science-based international food standards. When applying the guidance, it should be noted that there were circumstances in which children could not be breastfed. Member States should continue to build the evidence base on the best methods to promote breastfeeding and improve young child nutrition through an exchange of experiences and public health approaches. He looked forward to working with the Secretariat, Member States and other stakeholders to improve infant and child health.

The representative of CHINA, noting that steps had been taken in his country to implement the International Code of Marketing of Breast-milk Substitutes and to promote nutrition in poor areas, said that significant progress had been made. He supported WHO's efforts to end the inappropriate promotion of foods for infants and young children. His Government would formulate the appropriate policies and laws to follow WHO's guidance.

The representative of CANADA said that her country was pleased to sponsor the draft resolution on the Decade of Action on Nutrition. Her country looked forward to improving the nutrition of vulnerable populations. She endorsed the guidance on ending inappropriate promotion of foods for infants and young children, but would have preferred for it to refer to "so-called growing-up milks" since "growing-up milks" was not a technical term.

The representative of SENEGAL supported the adoption of both draft resolutions and encouraged continued efforts to promote breastfeeding.

The representative of BRAZIL wished to cosponsor the draft resolution on the Decade of Action on Nutrition and supported the draft resolution on ending inappropriate promotion of foods for infants and young children. It was essential for measures to be adopted to promote and protect healthy infant nutrition and breastfeeding. Brazil's national policies were aligned with WHO's guidance on promoting exclusive breastfeeding and the appropriate use of complementary feeding.

The representative of NEW ZEALAND endorsed the draft resolution and the guidance on ending inappropriate promotion of foods for infants and young children. Their adoption would motivate his Government to ensure that the country's childhood obesity plan was in line with WHO's recommendations. Timely implementation of the draft resolution on the Decade of Action on Nutrition, which the delegation of New Zealand had sponsored, would improve child health and help end childhood obesity.

The representative of the UNITED REPUBLIC OF TANZANIA said that a multisectoral approach had been adopted in her country to address malnutrition. She supported both draft resolutions.

The representative of INDONESIA, noting that a supportive environment was a key factor for successful implementation of food and nutrition policies, said that a number of regulations had been introduced in her country to promote good infant and young child feeding practices, which included limiting the advertisement of breast-milk substitutes for infants up to 6 months of age. Although the inappropriate promotion of foods had a negative impact on feeding practices, it could be countered by well-designed nutrition education programmes which enabled communities to practice optimal infant and young child feeding. She supported the draft resolution on ending inappropriate promotion of foods for infants and young children. She urged WHO to develop regional strategies to ensure the implementation of its guidance in order to attain the global nutrition targets for 2025 and the related Sustainable Development Goals.

The representative of FIJI, speaking on behalf of the Member States of the Western Pacific Region, supported both draft resolutions.

The representative of MEXICO said that factors that discouraged breastfeeding must continue to be mitigated through regulation and collaboration, especially with the private sector. She welcomed WHO's guidance and encouraged Member States to support the adoption of the draft resolution on ending inappropriate promotion of foods for infants and young children, which the delegation of Mexico had sponsored.

The representative of AUSTRALIA reiterated the longstanding position of his Government that WHO guidance should be drafted by the Secretariat, be technically correct, and be based on the best available evidence and expertise. He welcomed the consensus reached on the draft resolution on ending inappropriate promotion of foods to infants and young children. He requested more information on the financial and administrative implications for the Secretariat of resolutions proposed for adoption by the Executive Board or Health Assembly, staffing and proposed activities under the draft resolution on the Decade of Action on Nutrition.

The representative of ARGENTINA supported the draft resolution on ending inappropriate promotion of foods for infants and young children, as well as the implementation of the International Code of Marketing of Breast-Milk Substitutes.

The representative of THAILAND said that promotion and implementation of exclusive breastfeeding had been very challenging in Thailand, but significant effort was being made to pass a law that incorporated the International Code of Marketing of Breast-milk Substitutes. The draft resolution on ending inappropriate promotion of foods for infants and young children would provide tremendous support during that process. He urged the Assembly to adopt both draft resolutions.

The representative of GHANA said that an integrated nutrition policy for the promotion and regulation of nutrition had been developed in her country. She supported the draft resolution on ending inappropriate promotion of foods for infants and young children.

The representative of NIGER expressed support for both draft resolutions. A national plan with a multisectoral approach to address malnutrition had been developed in his country. He encouraged WHO and FAO to support Member States in the development and implementation of strategies to address malnutrition and reach the goals of the Decade of Action on Nutrition.

The representative of the RUSSIAN FEDERATION said that her country was continuing to take steps to support maternal, infant and young child nutrition. Insufficient and imbalanced nutrition was a major problem. Breastfeeding should be recommended as the best form of nutrition at the beginning of life. Health personnel and the mass media should convey accurate messages to the public and raise awareness of nutrition-related issues. She supported the adoption of both draft resolutions.

The representative of INDIA emphasized that all necessary measures to end the inappropriate promotion of foods for infants and young children should be taken, and that Member States had the right to go beyond WHO's guidance. Although he was concerned that the draft resolution had weakened the recommendations contained in the guidance, he supported its adoption. The Secretariat should make concerted efforts to strengthen the implementation of the document and guide Member States and other stakeholders in ending inappropriate promotion of foods for infants and young children. The Organization should also carry out a study on the impact of the marketing of vitamin and mineral supplements and provide guidance on ending the inappropriate promotion of those products.

The representative of EGYPT, speaking on behalf of the Member States of the Eastern Mediterranean Region, expressed appreciation for WHO's support to develop national action plans and achieve the global targets of the comprehensive implementation plan on maternal, infant and young child nutrition. Regular monitoring and surveillance systems were essential. WHO should provide technical and capacity-building support. International organizations and donors should streamline resources to support the plan. Member States must strengthen food systems, promote healthy diets and improve maternal health by enforcing regulations on marketing unhealthy food and breast-milk substitutes.

The representative of BANGLADESH expressed appreciation for the spirit in which the negotiations on the draft resolution on ending the inappropriate promotion of foods for infants and young children had been conducted. The proposed guidance would help Member States promote breastfeeding and healthy diets and prevent obesity and noncommunicable diseases.

The representative of FAO said that she welcomed the draft resolution on the Decade of Action on Nutrition. Member States should develop measurable, relevant and time-bound nutrition policies, with clear financial commitments. She called on WHO to support more research on multiple forms of malnutrition, which should be carried out by third parties without any vested interests in the outcome.

The observer of CHINESE TAIPEI said that healthy food at school and in kindergarten was mandatory in Chinese Taipei. The sale of food at school, the advertising and promotion of food products for children, and the sale of infant and follow-up formula were strictly regulated. Breast-milk

substitutes were properly labelled and the packages carried statements advocating the advantages of breastfeeding. He supported the draft resolution on ending the inappropriate promotion of foods for infants and small children and called on WHO to provide guidance on ways to avoid conflict of interest between children's health and the interests of manufacturers of breast-milk substitutes.

The observer of the HOLY SEE, quoting Pope Francis, said that solidarity must be put back at the heart of international relations. The Decade of Action on Nutrition provided an opportunity to reflect on the essential elements of well-being and stability in families, which were the most important determinants of health throughout the life course. The Catholic Church's experience with fighting hunger could be of value to governments and civil society. Faith-based initiatives at the community and family levels made a significant contribution to securing basic, healthy nutrition, mindful of the fact that the planet's resources were limited and must be used sustainably.

The representative of FDI WORLD DENTAL FEDERATION, speaking at the invitation of the CHAIRMAN, said that the consumption of free sugars was the primary dietary factor responsible for dental caries. Concerted, integrated efforts by parents, schools, the health industry and other stakeholders were needed to decrease sugar intake in all its forms. Strict regulation of advertising and of the promotion and labelling of food and drinks containing free sugars, especially those targeting children and young adults, was imperative.

The representative of HELEN KELLER INTERNATIONAL, speaking at the invitation of the CHAIRMAN, expressed concern about the intentional cross-promotion of follow-up formula and growing-up milks by industry. Such practices served to promote companies' entire line of infant milk products, thus undermining optimal breastfeeding. Companies also engaged in the inappropriate marketing of complementary foods and cross-branding to promote their infant formulas, in contravention of the International Code of Marketing of Breast-milk Substitutes. Although the draft resolution on ending inappropriate promotion of foods for infants and young children would have benefited from stronger language, her organization strongly supported its adoption. By adopting both resolutions under the agenda item, the Health Assembly would send a clear signal that child health must be placed above commercial interests.

The representative of the INTERNATIONAL BABY FOOD ACTION NETWORK, speaking at the invitation of the CHAIRMAN, expressed support for the draft resolution on ending inappropriate promotion of foods for infants and young children, although it was not worded as strongly as her organization would have liked. The profitability of the rapidly expanding baby foods market was the main obstacle to the struggle in many countries to protect children's health, especially in rich countries, where the interests of manufacturing companies were often put first. If WHO wanted to put babies before business, improve breastfeeding rates and prevent obesity and noncommunicable diseases, the adoption of the draft resolution was crucial.

The representative of MEDICUS MUNDI INTERNATIONAL – INTERNATIONAL ORGANISATION FOR COOPERATION IN HEALTH CARE, speaking at the invitation of the CHAIRMAN, concurred with previous speakers that the wording used in the draft resolution on ending inappropriate promotion of foods for infants and young children was not strong enough. It was deeply worrying that, 35 years after adoption, only 39 countries had incorporated the International Code of Marketing of Breast-milk Substitutes into national legislation. WHO, together with expert non-State actors, should assist Member States in identifying country-specific obstacles to implementing both the Code and subsequent WHO resolutions, sharing best practices on ways to limit the influence of the baby food industry. WHO should also assist Member States in developing regulatory policies for the food and beverage industry.

The representative of the INTERNATIONAL LACTATION CONSULTANT ASSOCIATION, speaking at the invitation of the CHAIRMAN, expressed concern at the statistics on the ill health of women and children caused by some form of malnutrition, and the low incidence of breastfeeding. The International Code of Marketing of Breast-milk Substitutes was a critical instrument and must be integrated into national legislation, implemented and monitored. In order to achieve that goal, political will was indispensable and the guidance on inappropriate promotion of foods for young children and infants was a step in the right direction.

The representative of THE SAVE THE CHILDREN FUND, speaking at the invitation of the CHAIRMAN, said that the endorsement by Member States of the guidance to end the inappropriate promotion of foods for infants and young children would help scale-up good breastfeeding practices, saving lives and money. The draft resolution should recognize the need to end cross-promotional marketing practices and provide clarity to governments and industry that the International Code covered all breast-milk substitutes. Although it was disappointing that the proposed guidance was not accompanied by a strong resolution, the adoption of the two draft resolutions under the item was crucial to protect children's health.

The representative of WORLD CANCER RESEARCH FUND INTERNATIONAL, speaking at the invitation of the CHAIRMAN, said that the Decade of Action on Nutrition must galvanize efforts to achieve existing global targets for improving maternal and child nutrition and health. Member States should endorse the relevant draft resolution; set ambitious national food and nutrition targets; implement the Framework for Action adopted by the Second International Conference on Nutrition; develop robust accountability mechanisms to review, report on and monitor commitments; align national agriculture, nutrition and noncommunicable disease strategies and related policies; prioritize actions which impacted different types of malnutrition; and protect public policy-making from undue commercial interests.

The representative of the WORLD OBESITY FEDERATION, speaking at the invitation of the CHAIRMAN, expressed disappointment that no consensus had been reached on full endorsement of the guidance on ending the inappropriate promotion of foods for infants and young children, which was a critical step forward in protecting breastfeeding and healthy diets. Member States must ensure full implementation and monitoring at the national level, with WHO support, in line with the International Code of Marketing of Breast-milk Substitutes and WHO recommendations on the marketing of foods and non-alcoholic beverages to children. The relevant Codex standards should be updated. Member States must also prevent undue influence of commercial interest on policy decisions.

The representative of WORLD VISION INTERNATIONAL, speaking at the invitation of the CHAIRMAN, welcomed the progress made towards achieving global nutrition targets but noted that 49% of countries did not have enough data to determine whether they were on course to meet them. She called on Member States and relevant stakeholders to increase accountability for resources allocated to implementing national nutrition plans and for increased investment in nutrition, particularly at subnational levels. She urged Member States to endorse the two draft resolutions and to ensure that mothers and caregivers were able to make choices on feeding infants and young children without undue commercial influence.

The representative of ACTION CONTRE LA FAIM INTERNATIONAL, speaking at the invitation of the CHAIRMAN, said that solutions to undernutrition were well-known and it was unacceptable that children died of hunger in the 21st century. Urgent action was needed to give each child the opportunity to lead a normal, healthy life by turning commitments into national targets. He called on WHO Member States to adopt strong resolutions that supported ambitious national nutrition targets, the close monitoring of progress, the better protection of young children from the inappropriate promotion of foods and the promotion of breastfeeding.

The representative of the INTERNATIONAL FEDERATION OF MEDICAL STUDENTS' ASSOCIATIONS, speaking at the invitation of the CHAIRMAN, said that nutrition increasingly contributed to a growing burden of disease, rather than health. Healthy environments must therefore be created where individuals, especially mothers, were encouraged to make healthy food choices. While commending the draft resolution on ending the inappropriate promotion of foods for infants and young children, he regretted that the most recent draft did not contain stronger language. Member States must use the opportunity to put children's health first and be accountable to their populations. His federation stood ready to join forces with WHO to deliver on that promise.

The representative of the GLOBAL ALLIANCE FOR IMPROVED NUTRITION, speaking at the invitation of the CHAIRMAN, said that, in order to reach the global nutrition targets for 2025, WHO Member States must support implementation of the Decade of Action on Nutrition; endorse the draft resolution on ending the inappropriate promotion of foods for infants and young children; and implement the proposed guidance, without hampering efforts to promote access to affordable nutritious foods for specific target groups. Enhanced political action was needed to support the Targets, tackling both under- and over-nutrition.

The ASSISTANT DIRECTOR-GENERAL (Noncommunicable Diseases and Mental Health), responding to the points raised, said that the Secretariat would look into the issue of inappropriate promotion of vitamins and minerals, as suggested by the representative of India. In response to the request by the representative of Australia, he said that WHO would certainly endeavour to conduct all activities under the Decade of Action on Nutrition within its technical and financial possibilities; any decision on additional expenditure would be discussed with Member States.

The Committee had identified the need to develop national targets and plans, with WHO support. WHO would cooperate with FAO to facilitate the setting and tracking of commitments under the Decade of Action on Nutrition. Together with UNICEF, the Organization had established a network to better monitor implementation of the International Code of Marketing of Breast-milk Substitutes, and to support Member States in the development and implementation of relevant legislation. WHO would also begin to develop tools to monitor implementation of the guidance on ending inappropriate promotion of foods for infants and small children, with particular attention to conflict-of-interest issues, in cooperation with nongovernmental organizations.

The draft resolution on the Decade of Action on Nutrition was approved.¹

The draft resolution on ending inappropriate promotion of foods for infants and young children was approved.²

3. PREPAREDNESS, SURVEILLANCE AND RESPONSE: Item 14 of the agenda (continued)

Promoting the health of migrants: Item 14.7 of the agenda (document A69/27)

The representative of GUATEMALA, speaking on behalf of the Member States of the Region of the Americas, said that unprecedented migration flows the world over were cause for concern and access to health services must be guaranteed for all persons, irrespective of their migration status. Particular attention should be paid to women, children and unaccompanied minors, who were especially vulnerable. Inequalities in access to quality health care services could not be addressed by

¹ Transmitted to the Health Assembly in the Committee's fifth report and adopted as resolution WHA69.8.

² Transmitted to the Health Assembly in the Committee's fifth report and adopted as resolution WHA69.9.

health systems alone; they required a multisectoral response, with a focus not only on the provision of health care, but also on addressing the social determinants of health. Migrants in transit must be taken into account.

The representative of SRI LANKA said that Sri Lanka was one of a few countries with a comprehensive migration and health policy that addressed the health issues related to outbound, inbound and internal migration and the health of families left behind by migrant workers. Concerted efforts must be made to include migrants in efforts to implement the 2030 Agenda for Sustainable Development, including by building health systems that were sensitive to their needs. WHO would be required to provide technical assistance to some Member States to enable them to implement national programmes for migration and health. Her Government welcomed WHO's cooperation with the International Organization for Migration on migration and health issues.

The representative of JAMAICA said that Jamaica had a robust active and passive surveillance system and continuous efforts were being made to raise public awareness about reporting the presence of migrants to the health services. Mechanisms were in place to provide health care services to migrants of all statuses from the moment of their arrival in Jamaica. A system was in place to conduct triage in order to determine care priorities, rapid assessments and testing for communicable and noncommunicable diseases, and to treat emergency conditions. Jamaica would benefit from technical assistance from WHO to build its national capacities in the areas of emergency risk management and electronic data capture and transfer.

The representative of AZERBAIJAN said that urgent measures were needed to address the situation of migrants and refugees in need. Health systems were responsible for a range of complex measures, which must take into account the health of migrants and remain vigilant with regard to the impacts of migration on the health of host populations. A multisectoral approach was essential, and international cooperation would be crucial; each country's efforts would be less effective if conducted in isolation. Innovative approaches must be taken with regard to surveillance and every effort must be made to develop a clear set of prioritized measures for the prevention and care for all migrants and members of their families.

The representative of ERITREA, speaking on behalf of the Member States of the African Region, said that all Member States had a legal and moral obligation to provide health care to all migrants and refugees without discrimination. Despite international instruments in place to protect the rights of migrants and refugees, barriers to their access to health persisted, leaving many at risk. He welcomed the eight priorities for future action identified in paragraph 11 of the report.

The representative of SENEGAL said that health and migration were inextricably linked and access to health care for migrants should be considered as a human rights issue. His Government welcomed the eight priorities identified in the report and urged all Member States to implement them as a matter of urgency.

The representative of ARGENTINA said that, while different categories of migrants required different health care approaches, the right to health for all must be protected. She noted that the report did not make reference to the Americas, despite the large flows of internal migration in the Region. She welcomed the eight priorities identified, in particular the priority to develop or strengthen bilateral and multilateral social protection agreements between source and destination countries to include portable health care benefits; furthermore, in the context of reciprocity, consideration must be given to migrant health workers.

The representative of JORDAN, speaking on behalf of the Member States of the Eastern Mediterranean Region, said that three of the world's Grade 3 emergencies and a number of other

protracted crises were taking place in the Eastern Mediterranean Region, which had resulted, thus far, in the displacement of some 30 million people. Member States in the Region had shown generous hospitality towards displaced populations, with many refugees being hosted by local communities with whom they competed for jobs, health care and other services. The cumulative public health consequences of mass movement in the Region were profound and enduring and must be addressed as a matter of urgency. The international community's efforts to provide assistance must be stepped up to ensure that the basic needs of displaced populations and local host communities could be met, and access to life-saving health services guaranteed. As populations continued to cross borders, greater cooperation between countries and regions was required to ensure a comprehensive and holistic approach to ensuring health care for all. Cooperation between relevant international organizations and agencies was also crucial to sustain systematic and meaningful support for Member States.

The representative of GREECE said that more than a million migrants and refugees had arrived in Greece since 2015, a number that was exceeding the capacity of designated sites and settlements. The main health care issues included trauma, respiratory tract infections, chronic diseases, gastrointestinal diseases and skin conditions. Measures were being taken to ensure an appropriate standard of living for all and to take the necessary measures for chronic disease management, vaccinations, health care for new mothers, food inspections and mosquito control methods. Versatility and a strong political will could shift the perspective on the migration situation from negativity to an opportunity to strengthen public health policies. The European strategy and action plan for refugee and migrant health in the WHO European Region, due to be adopted by the WHO Regional Committee for Europe at its 66th session in September 2016, would be a crucial tool to assist and guide collaborative international efforts to strengthen public health and promote respect for human rights.

The representative of LEBANON said that, since 2011, there had been a large and continuous influx of Syrian refugees into Lebanon. Health information systems had been immediately redesigned to include continuous assessment and reporting on issues related to the displaced Syrian population, including immunization coverage, disease surveillance, the health services used, and maternal and child mortality. Despite erratic international assistance during the crisis, all services provided through the national primary health care network had been given free of charge. The health system had thus been overstretched and the Government had been obliged to reallocate funds to sustain the financing of services at all levels. Despite those efforts, gaps in services persisted, and had a significant impact on individuals' health and on Lebanese institutions. The crisis in Syria was still ongoing and Lebanon's health system required considerable support to withstand the continuing challenge.

The representative of the PHILIPPINES said that the development of bilateral and multilateral social protection agreements between countries of origin, transit and destination was the key to safe, orderly, regular migration. In line with the call made by the WHO Director-General at the 106th Council of the International Organization for Migration, her Government was developing a national policy framework on migrants' health. Monitoring and periodic reporting by Member States on the state of migrant health would be useful.

The representative of ITALY said that his Government had tailored its policies and services to protect and promote the physical and mental health of refugees and migrants, and to prevent discrimination and violence. Comprehensive immunization programmes had been put in place, and active surveillance systems had been set up. Special care was offered to children, pregnant women, elderly people, people with disabilities and victims of torture. Effective provision of health care required flexibility to adapt to the needs of a changing population and to take account of cultural, religious, linguistic and gender diversity. When considering migration and health, attention should be paid to the prominent role of human trafficking organizations, and the number of migrants' lives lost in dangerous sea crossings. Consideration should also be given to the need to promote a migrant-sensitive culture in countries of transit and destination. Cooperation between countries and between

international organizations was crucial. His Government urged the Director-General to prepare a resolution for the Seventieth World Health Assembly, to update resolution WHA61.17 on the health of migrants, which had been adopted in 2008. The work done by the Regional Office for Europe to draft a strategy and action plan for refugee and migrant health in the WHO European Region could be used as an example in that regard.

The representative of INDONESIA said that the international community was facing a large number of migration-related social, economic and political problems, particularly as a result of conflicts in the Middle East. The migration crisis constituted a humanitarian issue that must be resolved as a matter of urgency, in a comprehensive response. Health services for migrants should be provided through a cluster approach, including health care, surveillance for disease control, environmental health such as water quality and supply and sanitation, nutrition, reproductive health, and information management. WHO had a key role to play in ensuring that international processes remained sufficiently flexible to be adapted to national contexts.

(For continuation of the discussion, see the summary record of the thirteenth meeting, section 4).

The meeting rose at 12:30.

THIRTEENTH MEETING

Saturday, 28 May 2016, at 14:10

Chairman: Mr M. BOWLES (Australia)

1. WHO REFORM: Item 11 of the agenda (continued)

Framework of engagement with non-State actors: Item 11.3 of the agenda (documents A69/6, A69/60 and EB138/2016/REC/1, decision EB138(3)) (continued from the first meeting, section 2)

The CHAIRMAN recalled that a drafting group had been established to finalize the draft framework of engagement with non-State actors. The text agreed on by the drafting group was contained in the Annex to the following draft resolution:

The Sixty-ninth World Health Assembly,

PP1 Having considered the report on the framework of engagement with non-State actors and the revised draft framework of engagement with non-State actors;¹

PP2 Recalling resolution WHA64.2 and decision WHA65(9) on WHO reform, and decisions WHA67(14), EB136(3), EB138(3) and resolution WHA68.9 on a framework of engagement with non-State actors;

PP3 Recalling also the United Nations General Assembly resolution 70/1 “Transforming our world: the 2030 Agenda for Sustainable Development”, and the equally important Goals, targets and means of implementation, which calls, inter alia, for a revitalized global partnership for sustainable development, based on the spirit of strengthened global solidarity, focused in particular on the needs of the poorest and most vulnerable and with participation of all countries, all stakeholders and all people;

PP4 Recalling also United Nations General Assembly resolution 69/313 on the Addis Ababa Action agenda of the third international conference on financing for development, which is an integral part of the 2030 Agenda for Sustainable Development;

PP5 Recalling further the 2014 “Rome Declaration on Nutrition and the Framework for Action on Nutrition”;

PP6 Underscoring the full political commitment of all Member States towards the consistent and coherent implementation of the framework of engagement with non-State actors across the three levels of the Organization,

(OP1) ADOPTS the Framework of Engagement with non-State actors, as set out in the Annex to this resolution;²

(OP2) DECIDES that the Framework of Engagement with non-State actors shall replace the Principles governing relations between the World Health Organization and

¹ Document A69/6.

² Consisting of an overarching framework and four specific policies on engagement with nongovernmental organizations, private sector entities, philanthropic foundations and academic institutions.

nongovernmental organizations¹ and Guidelines on interaction with commercial enterprises to achieve health outcomes;²

(OP3) REQUESTS the Director General:

- (1) To immediately start implementation of the Framework of Engagement with non-State actors;
- (2) To take all necessary measures, working with regional directors, to fully implement the framework in a coherent and consistent manner across all three levels of the Organization, with a view to achieving full operationalization within a two year timeframe;
- (3) to expedite the full establishment of the register of non-State actors in time for the Seventieth World Health Assembly;
- (4) to report on the implementation of the Framework of Engagement with non-State actors to the Executive Board at each of its January sessions under a standing agenda item, through the Programme Budget and Administration Committee;
- (5) to include in the report on the implementation of the Framework on Engagement with non-State actors, when deemed necessary, any matter or types of engagement with non-State actors that would benefit from further consideration by the Executive Board, through the Programme Budget and Administration Committee, due to their unique characteristics and relevance;
- (6) to conduct an initial evaluation in 2019 of the implementation of the Framework of Engagement with non-State actors and its impact on the work of WHO with a view to submitting the results, together with any proposals for revisions of the Framework, to the Executive Board in January 2020, through the Programme Budget and Administration Committee;
- (7) to include in the guide to staff, measures that pertain to application of the relevant provisions contained in the existing WHO policies on conflict of interest, with a view to facilitating the implementation of Framework of Engagement with non-State actors;
- (8) to develop, in consultation with Member States, a set of criteria and principles for secondments from nongovernmental organizations, philanthropic foundations and academic institutions and to submit the criteria and principles for the consideration and establishment, as appropriate, by the Seventieth World Health Assembly, through the Executive Board, taking into account amongst others the following identified issues:
 - (a) specific technical expertise needed and excluding managerial and/or sensitive positions;
 - (b) the promotion of equitable geographical distribution;
 - (c) transparency and clarity around positions sought, including public announcements;
 - (d) secondments are temporary in nature not exceeding two years;
- (9) to make reference to secondments from non-State actors in the annual report on engagement with non-State actors to be submitted, including justification behind secondments;

OP4 REQUESTS the Independent Expert Oversight Advisory Committee, in accordance with its current terms of reference, to include a section on the implementation of Framework of Engagement with non-State actors in its report to the Programme, Budget and Administration Committee of the Executive Board at each January session;

¹ Adopted in resolution WHA40.25. See Basic documents, 48th ed. Geneva: World Health Organization; 2014.

² Document EB107/20, Annex.

OP5 REQUESTS the Seventieth World Health Assembly to review progress on the implementation at the three levels of the Organization, with a view to taking any decisions necessary to enable the full, coherent and consistent implementation of the Framework of Engagement with non-State actors.

ANNEX

FRAMEWORK OF ENGAGEMENT WITH NON-STATE ACTORS

OVERARCHING FRAMEWORK OF ENGAGEMENT WITH NON-STATE ACTORS

INTRODUCTION

1. The overarching framework of engagement with non-State actors and the WHO policy and operational procedures on management of engagement with non-State actors apply to all engagements with non-State actors at all levels of the Organization,¹ whereas the four specific policies and operational procedures on engagement are limited in application to, respectively, nongovernmental organizations, private sector entities, philanthropic foundations and academic institutions.

ENGAGEMENT: RATIONALE, PRINCIPLES, BENEFITS AND RISKS

Rationale

2. WHO is the directing and coordinating authority in global health in line with its constitutional mandate. The global health landscape has become more complex in many respects; among other things, there has been an increase in the number of players including non-State actors. WHO engages with non-State actors in view of their significant role in global health for the advancement and promotion of public health and to encourage non-State actors to use their own activities to protect and promote public health.

3. The functions of WHO, as set out in Article 2 of its Constitution, include: to act as the directing and coordinating authority on international health work; to establish and maintain effective collaboration with diverse organizations; and to promote cooperation among scientific and professional groups which contribute to the advancement of health. The Constitution further mandates the Health Assembly or the Executive Board, and the Director-General, to enter into specific engagements with other organizations.² WHO shall, in relation to non-State actors, act in conformity with its Constitution and resolutions and decisions of the Health Assembly, and bearing in mind those of the United Nations General Assembly or the Economic and Social Council of the United Nations, if applicable.

¹ Headquarters, regional offices and country offices, entities established under WHO, as well as hosted partnerships. For hosted partnerships the framework of engagement with non-State actors will apply, subject to the policy on WHO's engagement with global health partnerships and hosting arrangements (resolution WHA63.10). Hosted, as well as external partnerships are explained in paragraph 48.

² WHO Constitution, Articles 18, 33, 41 and 71.

4. **(DELETED)**

5. WHO's engagement with non-State actors supports implementation of the Organization's policies and recommendations as decided by the governing bodies, as well as the application of WHO's technical norms and standards. Such an effective engagement with non-State actors at global, regional and country levels, also calls for due diligence and transparency measures applicable to non-State actors under this framework. In order to be able to strengthen its engagement with non-State actors for the benefit and interest of global public health, WHO needs simultaneously to strengthen its management of the associated potential risks. This requires a robust framework that enables engagement and serves also as an instrument to identify the risks, balancing them against the expected benefits, while protecting and preserving WHO's integrity, reputation and public health mandate.

Principles

6. WHO's engagement with non-State actors is guided by the following overarching principles.

Any engagement must:

- (a) demonstrate a clear benefit to public health;
- (a bis) conform with WHO's Constitution, mandate and general programme of work
- (b) respect the intergovernmental nature of WHO and the decision-making authority of Member States as set out in the WHO's Constitution;
- (c) support and enhance, without compromising, the scientific and evidence-based approach that underpins WHO's work;
- (d) protect WHO from any undue influence, in particular on the processes in setting and applying policies, norms and standards;¹
- (e) not compromise WHO's integrity, independence, credibility and reputation;
- (f) be effectively managed, including by, where possible avoiding conflict of interest² and other forms of risks to WHO;
- (g) be conducted on the basis of transparency, openness, inclusiveness, accountability, integrity and mutual respect.

Benefits of engagement

7. WHO's engagement with non-State actors can bring important benefits to global public health and to the Organization itself in fulfilment of its constitutional principles and objectives, including its directing and coordinating role in global health. Engagements range from major, longer-term collaborations to smaller, briefer interactions. Benefits arising from such engagement can also include:

¹ Policies, norms and standard setting includes information gathering, preparation for, elaboration of and the decision on the normative text.

² As set out in paragraphs 23 to 26.

- (a) (DELETED)
- (b) the contribution of non-State actors to the work of WHO
- (c) the influence that WHO can have on non-State actors to enhance their impact on global public health or to influence the social, economic and environmental determinants of health
- (d) the influence that WHO can have on non-State actors' compliance with WHO's policies, norms and standards
- (e) the additional resources non-State actors can contribute to WHO's work
- (f) the wider dissemination of and adherence by non-State actors to WHO's policies, norms and standards

Risks of engagement

8. WHO's engagement with non-State actors can involve risks which need to be effectively managed and, where appropriate, avoided. Risks relate inter alia to the occurrence in particular of the following:

- (a) conflicts of interest;
- (b) undue or improper influence exercised by a non-State actor on WHO's work, especially in, but not limited to, policies, norms and standard setting;¹
- (c) a negative impact on WHO's integrity, independence, credibility and reputation; and public health mandate;
- (d) the engagement being primarily used to serve the interests of the non-State actor concerned with limited or no benefits for WHO and public health;
- (e) the engagement conferring an endorsement of the non-State actor's name, brand, product, views or activity;²
- (f) the whitewashing of a non-State actor's image through an engagement with WHO;
- (g) a competitive advantage for a non-State actor.

NON-STATE ACTORS

9. For the purpose of this framework, non-State actors are nongovernmental organizations, private sector entities, philanthropic foundations and academic institutions.

¹ Policies, norms and standard setting includes information gathering, preparation for, elaboration of and the decision on the normative text.

² Endorsement does not include established processes such as prequalifications or the WHO Pesticide Evaluation Scheme (WHOPES).

10. **Nongovernmental organizations** are non-profit entities that operate independently of governments. They are usually membership-based, with non-profit entities or individuals as members exercising voting rights in relation to the policies of the nongovernmental organization, or are otherwise constituted with non-profit, public-interest goals. They are free from concerns which are primarily of a private, commercial or profit-making nature. They could include, for example, grassroots community organizations, civil society groups and networks, faith-based organizations, professional groups, disease-specific groups, and patient groups.

11. **Private sector** entities are commercial enterprises, that is to say businesses that are intended to make a profit for their owners. The term also refers to entities that represent, or are governed or controlled by, private sector entities. This group includes (but is not limited to) business associations representing commercial enterprises, entities not “at arm’s length”¹ from their commercial sponsors, and partially or fully State-owned commercial enterprises acting like private sector entities.

International business associations are private sector entities that do not intend to make a profit for themselves but represent the interests of their members, which are commercial enterprises and/or national or other business associations. For the purposes of this framework, they shall have the authority to speak for their members through their authorized representatives. Their members shall exercise voting rights in relation to the policies of the international business association.

12. **Philanthropic foundations** are non-profit entities whose assets are provided by donors and whose income is spent on socially useful purposes. They shall be clearly independent from any private sector entity in their governance and decision-making.

13. **Academic institutions** are entities engaged in the pursuit and dissemination of knowledge through research, education and training.²

14. For each of the four groups of entities above, the overarching framework and the respective specific policy on engagement apply. WHO will determine through its due diligence if a non-State actor is subject to the influence of private sector entities to the extent that the non-State actor has to be considered itself a private sector entity. Such influence can be exerted through financing, participation in decision making or otherwise. Provided that the decision-making processes and bodies of a non-State actor remain independent of undue influence from the private sector, WHO can decide to consider the entity as a nongovernmental organization, a philanthropic foundation or an academic institution, but may apply relevant provisions of the WHO’s policy and operational procedures on engagement with private sector entities, such as not accepting financial and in-kind contributions for use in the normative work.

TYPES OF INTERACTION

15. The following are categories of interaction in which WHO engages with non-State actors. Each type of interaction can take different forms, be subject to different levels of risk and can involve different levels and types of engagement by the Organization.

¹ An entity is “at arm’s length” from another entity if it is independent from the other entity, does not take instructions and is clearly not influenced or clearly not reasonably perceived to be influenced in its decisions and work by the other entity.

² This can include think tanks which are policy-oriented institutions, as long as they primarily perform research; while international associations of academic institutions are considered as non-governmental organizations, subject to paragraph 14.

Participation

16. Non-State actors may attend various types of meetings organized by WHO. The nature of their participation depends on the type of meeting concerned. The format, modalities, and the participation of non-State actors in consultations, hearings, and other meetings is decided on a case-by-case basis by the WHO governing bodies or by the Secretariat.

(a) **Meetings of the governing bodies.** This type involves sessions of the World Health Assembly, the Executive Board and the six regional committees. Non-State actors' participation is determined by the governing bodies' respective rules of procedure, policies and practices as well as the section of this framework that deals with official relations.

(b) **Consultations.** This type includes any physical or virtual meeting, other than governing body sessions, organized for the purpose of exchanging information and views. Inputs received from non-State actors shall be made publicly available, wherever possible.

(c) **Hearings.** These are meetings in which the participants can present their evidence, views and positions and be questioned about them but do not enter into a debate. Hearings can be electronic or in person. All interested entities should be invited on the same basis. The participants and positions presented during hearings shall be documented and shall be made publicly available, wherever possible.

(d) **Other meetings.** These are meetings that are not part of the process of setting policies, norms or standards; examples include information meetings, briefings, scientific conferences, and platforms for coordination of actors.

17. WHO's involvement in meetings organized wholly or partly by a non-State actor can – subject to the provisions of this framework, its four specific policies and operational procedures, and other applicable WHO rules, policies and procedures – consist of any one of the following possibilities:

- WHO jointly organizes the meeting with the non-State actor
- WHO cosponsors a meeting¹ organized by the non-State actor
- WHO staff make a presentation or act as panellists at a meeting organized by the non-State actor
- WHO staff attend a meeting organized by a non-State actor.

¹ Cosponsorship of a meeting means: (1) another entity has the primary responsibility for organizing the meeting; and (2) WHO supports and contributes to the meeting and its proceedings; and (3) WHO reserves the right to clear the agenda of the meeting, the list of participants and the outcome documents of the meeting.

Resources

18. Resources are financial or in-kind contributions. In-kind contributions include donations of medicines and other goods and free provision of services¹ on a contractual basis.

Evidence

19. For the purposes of this framework, evidence refers to inputs based on up-to-date information, knowledge on technical issues, and consideration of scientific facts, independently analysed by WHO. Evidence generation by WHO includes information gathering, analysis, generation of information and the management of knowledge and research. Non-State actors may provide their up-to-date information and knowledge on technical issues, and share their experience with WHO, as appropriate, subject to the provisions of this framework, its four specific policies and operational procedures, and other applicable WHO rules, policies and procedures. Such contribution should be made publicly available, as appropriate, wherever possible. Scientific evidence generated should be made publicly available.

Advocacy

20. Advocacy is action to increase awareness of health issues, including issues that receive insufficient attention; to change behaviours in the interest of public health; and to foster collaboration and greater coherence between non-State actors where joint action is required.

Technical collaboration

21. For the purpose of this framework, technical collaboration refers to other collaboration with non-State actors, as appropriate, in activities that fall within the General Programme of Work, including:

- product development
- capacity-building
- operational collaboration in emergencies
- contributing to the implementation of WHO's policies.

MANAGEMENT OF CONFLICT OF INTEREST AND OTHER RISKS OF ENGAGEMENT

22. Managing, including by, where appropriate, avoiding, conflict of interest and other risks of engagement requires a series of steps, as set out below:²

¹ With the exception of secondments, which are covered in paragraph 46.

² The framework is designed to regulate institutional engagements; its implementation is closely coordinated with the implementation of other organizational policies regulating conflict of interest in respect of individuals (see paragraph 48).

- WHO needs to know the non-State actors that it engages with. Therefore each non-State actor is required to provide all relevant¹ information about itself and its activities, following which WHO conducts the necessary due diligence.
- WHO conducts a risk assessment in order to identify the specific risks of engagement associated with each engagement with a non-State actor.
- Risks of engagement need to be managed and communicated coherently in each of the three levels of the Organization and throughout the Organization. To that end, WHO manages engagement through a single, Organization-wide electronic tool.²
- Member States exercise oversight over WHO's engagement with non-State actors in accordance with the provisions in paragraphs 65 and 66.

Conflict of interest

23. A conflict of interest arises in circumstances where there is potential for a secondary interest (a vested interest in the outcome of WHO's work in a given area) to unduly influence, or where it may be reasonably perceived to unduly influence, either the independence or objectivity of professional judgement or actions regarding a primary interest (WHO's work). The existence of conflict of interest in all its forms does not as such mean that improper action has occurred, but rather the risk of such improper action occurring. Conflicts of interest are not only financial, but can take other forms as well.

23bis Individual conflicts of interests within WHO are those involving experts, regardless of their status, and staff members; these are addressed in accordance with the policies listed under paragraph 48 of the present framework.

24. All institutions have multiple interests, which means that in engaging with non-State actors WHO is often faced with a combination of converging and conflicting interests. An **institutional conflict of interest** is a situation where WHO's primary interest as reflected in its Constitution may be unduly influenced by the conflicting interest of a non-State actor in a way that affects, or may reasonably be perceived to affect, the independence and objectivity of WHO's work.

25. In actively managing institutional conflict of interest and the other risks of engagement mentioned in paragraph 8 above, WHO aims to avoid allowing the conflicting interests of a non-State actor to exert, or be reasonably perceived to exert, undue influence over the Organization's decision-making process or to prevail over its interests.

26. For WHO, the potential risk of institutional conflicts of interest could be the highest in situations where the interest of non-State actors, in particular economic, commercial or financial, are in conflict with WHO's public health policies, constitutional mandate and interests, in particular the Organization's independence and impartiality in setting policies, norms and standards.

¹ As defined in paragraph 38bis.

² WHO uses an electronic tool for managing engagement. As described in footnote 1 of paragraph 38, the publicly visible part of the tool is the register of non-State actors; the tool also provides an electronic workflow for the internal management of engagement. A similar electronic tool is used for the management of individual conflicts of interest, in order to harmonize the implementation of the framework with the implementation of the policy on management of individual conflicts of interest for experts.

Due diligence and risk assessment

27. When the possibility of entering into an engagement is being considered, the relevant technical unit in the Secretariat conducts an initial examination in order to establish whether such an engagement would be in the interest of the Organization and in line with the principles of WHO's engagement with non-State actors in paragraph 6 and the priorities defined in the General Programme of Work and Programme budget. If this seems to be the case, the technical unit **consults the WHO Register on non-State actors and as needed** asks the non-State actor to provide its basic information. Using the Organization-wide electronic tool, the unit then complements this information with a description of the proposed engagement and its own assessment of the benefits and risks involved, as needed.

27bis (new) The technical unit makes an initial assessment. If the engagement is of low risk, for example because of its repetitive nature¹ or because it does not involve policies, norms and standard setting, a simplified due diligence and risk assessment modulating the procedures in paragraphs 28 to 36 as well as 38bis can be performed by the technical unit and the risk management decision taken, taking such steps as are necessary to ensure full compliance with paragraphs 6 to 8.² For all other engagements full procedures apply.

28. Before engaging with any non-State actor, WHO, in order to preserve its integrity, conducts due diligence and risk assessment. **Due diligence** refers to the steps taken by WHO to find and verify relevant information on a non-State actor and to reach a clear understanding of its profile. While due diligence refers to the nature of the non-State actor concerned, **risk assessment** refers to the assessment of a specific proposed engagement with that non-State actor.

29. **Due diligence** combines a review of the information provided by the non-State actor, a search for information about the entity concerned from other sources, and an analysis of all the information obtained. This includes a screening of different public, legal and commercial sources of information, including: media; the entity's website companies' analyst reports, directories and profiles; and public, legal and governmental sources.

30. The core functions of due diligence are to:

- clarify the nature and purpose of the entity proposed to engage with WHO;
- clarify the interest and objectives of the entity in engaging with WHO and what it expects in return;
- determine the entity's legal status, area of activities, membership, governance, sources of funding, constitution, statutes, and by-laws and affiliation;
- define the main elements of the history and activities of the entity in terms of the following: health, human and labour issues; environmental, ethical and business issues; reputation and image; and financial stability;
- identify if paragraph 44 or 44bis should be applied.

¹ Provided that due diligence and risk assessment have already been carried out and the nature of engagement has remained unchanged.

² The simplified due diligence and risk assessment, and information to be provided by non-State actors as well as the criteria of low risk engagements are described in the guide for staff.

31. Due diligence also allows the Secretariat for the purpose of its engagement to categorize each non-State actor in relation to one of the four groups of non-State actors on the basis of its nature, objectives, governance, funding, independence and membership. This categorization is indicated in the register of non-State actors.

32. Risks are the expression of the likelihood and potential impact of an event that would affect the Organization's ability to achieve its objectives. A **risk assessment** on a proposed engagement is conducted in addition to due diligence. This involves the assessment of risks associated with an engagement with a non-State actor, in particular the risks described in paragraph 8 and is to be conducted without prejudice to the type of non-State actor.

Risk management

33. **Risk management** concerns the process leading to a management decision whereby the Secretariat decides explicitly and justifiably on entry into engagement,¹ continuation of engagement, engagement with measures to mitigate risks, non-engagement or disengagement from an existing or planned engagement with non-State actors. It is a management decision usually taken by the unit engaging with the non-State actor based on a recommendation of the specialized unit responsible for performing due diligence and risk assessment.

34 – DELETED

35. A dedicated secretariat mechanism reviews proposals of engagement referred to it and recommends engagement, continuation of engagement, engagement with measures to mitigate risks, non engagement or disengagement from an existing or planned engagement with non-State actors. The DG, working with RDs, ensures coherence and consistency in implementation and interpretation of this Framework across all levels of the Organization.

36. WHO takes a risk-management approach to engagement, only entering into an engagement with a non-State actor when the benefits in terms of direct or indirect contributions to public health and the fulfilment of the Organization's mandate as mentioned in paragraph 7 outweigh any residual risks of engagement as mentioned in paragraph 8, as well as the time and expense involved in establishing and maintaining the engagement.

Transparency

37. WHO's interaction with non-State actors is managed transparently. WHO provides an annual report to the governing bodies on its engagement with non-State actors, including summary information on due diligence, risk assessment and risk management undertaken by the Secretariat. WHO also makes publicly available appropriate information on its engagement with non-State actors.

38. The **WHO register of non-State actors** is an Internet-based, publicly available electronic tool used by the Secretariat² to document and coordinate engagement with non-State actors. It contains the

¹ Other than decisions related to official relations as set out in paragraphs 49 to 55.

² The register of non-State actors is the first level of a tool used by the Secretariat containing four levels of information: a publicly available level, a level made available to Member States, a working level for the Secretariat, and a level of confidential and sensitive information accessible to a limited number of individuals within the Secretariat.

main standard information provided by non-State actors¹ and high-level descriptions of the engagement that WHO has with these actors.²

38bis Non-State actors engaging with WHO are required to provide information on their organization. This information includes: name, membership, legal status, objective, governance structure, composition of main decision-making bodies, assets, annual income and funding sources, main relevant affiliations, webpage and one or more focal points for WHO contacts.

39. When the Secretariat decides on an engagement with a non-State actor, a summary of the information submitted by that entity and held in the WHO register of non-State actors is made public. The accuracy of the information provided by the non-State actor and published in the register is the responsibility of the non-State actor concerned and does not constitute any form of endorsement by WHO.

40. Non-State actors described in the register must update the information provided on themselves annually or upon the request of WHO. Information in the WHO register of non-State actors will be dated. Information on entities that are no longer engaged with WHO or that have not updated their information will be marked as “archived”. Archived information from the WHO register of non-State actors can be considered in relation to future applications for engagement, where relevant.

40bis (moved from 38ter) In addition to the publicly available information, Member States have electronic access to a summary report on due diligence of each non-State actor and their respective risk assessment and risk management on engagement. Member States also have access, on demand, to the associated full report through a remote secure access platform.

41. WHO maintains a handbook to guide non-State actors in their interaction with WHO in line with this framework. A guide for staff is also maintained on the implementation of the framework of engagement with non-State actors.

42. (DELETED)

43. (DELETED)

SPECIFIC PROVISIONS

44. WHO does not engage with the tobacco industry or non-State actors that work to further the interests of the tobacco industry. WHO also does not engage with the arms industry.

Engagement where particular caution should be exercised

44bis WHO will exercise particular caution, especially while conducting due diligence, risk assessment and risk management, when engaging with private sector entities and other non-State actors whose policies or activities are negatively affecting human health and are not in line with WHO’s policies, norms and standards, in particular those related to noncommunicable diseases and their determinants.

¹ Information on financial contributions received from non-State actors is documented in this register and in the Programme Budget web portal.

² The register covers all three levels of the Organization – global, regional and country – and includes hosted partnerships and joint programmes.

Association with WHO's name and emblem

45. WHO's **name and emblem** are recognized by the public as symbols of integrity and quality assurance. WHO's name, acronym and emblem shall not, therefore, be used for, or in conjunction with, commercial, promotional marketing and advertisement purposes. Any use of the name or emblem needs an explicit written authorization by the Director-General of WHO.¹

Secondments

46. WHO does not accept secondments from private sector entities.

RELATION OF THE FRAMEWORK TO WHO'S OTHER POLICIES

47. This framework replaces the Principles Governing Relations between the World Health Organization and Nongovernmental Organizations² and the Guidelines on interaction with commercial enterprises to achieve health outcomes (noted by the Executive Board).³

48. The implementation of the policies listed below as they relate to WHO's engagement with non-State actors will be coordinated and aligned with the framework of engagement with non-State actors. In the event that a conflict is identified, it will be brought to the attention of the Executive Board through the PBAC.

(a) Policy on WHO's engagement with global health partnerships and hosting arrangements.⁴

(i) Hosted partnerships derive their legal personality from WHO and are subject to the Organization's rules and regulations. Therefore the Framework of engagement with non-State actors applies to their engagement with non-State actors. They have a formal governance structure, separate from that of the WHO governing bodies, in which decisions are taken on direction, workplans and budgets; and their programmatic accountability frameworks are also independent from those of the Organization. In the same way the framework applies to other hosted entities which are subject to the Organizations Rules and Regulations.

(ii) WHO's involvement in external partnerships is regulated by the policy on WHO's engagement with global health partnerships and hosting arrangements. The framework of engagement with non-State actors also applies to WHO's engagement in these partnerships.⁵

(b) Regulations for Expert Advisory Panels and Committees and the Guidelines for Declaration of Interests (WHO Experts). The management of WHO's relations with individual

¹ See <http://www.who.int/about/licensing/emblem/en/>.

² Basic documents, 48th ed. Geneva: World Health Organization; 2014: pp.97–102.

³ See document EB107/2001/REC/2, summary record of the twelfth meeting.

⁴ Endorsed by the Health Assembly in resolution WHA63.10 on partnerships and its Annex 1.

⁵ The Codex Alimentarius Commission is an intergovernmental body which is the principal organ of the joint FAO/WHO food standards programme for which the administration is not solely provided by WHO. The Commission is supported by subsidiary bodies including Codex committees, regional coordinating committees and task forces. Meetings of the Commission, Committees, including independent expert committees, and Task Forces are regulated by the Rules of Procedure and other decisions adopted by the Codex Alimentarius Commission.

experts is regulated by the Regulations for Expert Advisory Panels and Committees¹ and the Guidelines for Declaration of Interests (WHO Experts).

(c) Staff Regulations and Staff Rules. All staff are subject to the Organization's Staff Regulations and Staff Rules, noting in particular the provisions of declaration of interest therein: according to Article 1.1 of the Staff Regulations of the World Health Organization, all staff members "pledge themselves to discharge their functions and to regulate their conduct with the interests of the World Health Organization only in view."

(d) Regulations for Study and Scientific Groups, Collaborating Institutions and other Mechanisms of Collaboration. Scientific collaborations are regulated by the Regulations for Study and Scientific Groups, Collaborating Institutions and other Mechanisms of Collaboration.²

(e) Financial Rules and Financial Regulations.

(i) The procurement of goods and services is regulated by the Financial Rules and Financial Regulations;³ it is not covered by the framework of engagement with non-State actors, although pro-bono contributions from non-State actors are covered.

(ii) Like any other financing of WHO, financing from non-State actors is regulated by the Financial Rules and Financial Regulations and the decision on accepting such financial contributions is also regulated by this framework.

OFFICIAL RELATIONS

49. **"Official relations"** is a privilege that the Executive Board may grant to nongovernmental organizations, international business associations and philanthropic foundations that have had and continue to have a sustained and systematic engagement⁴ in the interest of the Organization. The aims and activities of all these entities shall be in conformity with the spirit, purposes and principles of WHO's Constitution, and they shall contribute significantly to the advancement of public health. Organizations in official relations can attend governing body meetings of WHO but are otherwise subject to the same rules as other non-State actors when engaging with WHO.

50. Entities in official relations are international in membership and /or scope. All entities in official relations shall have a constitution or similar basic document, an established headquarters, a governing body, an administrative structure, and a regularly updated entry in the WHO register of non-State actors.

51. Official relations shall be based on a plan for collaboration between WHO and the entity with agreed objectives and outlining activities for the coming three-year period structured in accordance with the General Programme of Work and Programme budget and consistent with this framework.

¹ See Basic documents, 48th ed. Geneva: World Health Organization; 2014: pp.121–130.

² Basic documents, 48th ed. Geneva: World Health Organization; 2014: pp.131–138.

³ Basic documents, 47th ed. Geneva: World Health Organization; 2009, pp.87–97. 48th ed. Geneva: World Health Organization; 2014: pp.103–113.

⁴ At least two years of systematic engagement as documented in the WHO register of non-State actors, assessed by both parties to be mutually beneficial. Participation in each other's meetings alone is not considered to be a systematic engagement.

This plan shall also be published in the WHO register of non-State actors. These organizations shall provide annually a short report on the progress made in implementing the plan of collaboration and other related activities which will also be published in the WHO register. These plans shall be free from concerns which are primarily of a commercial or profit-making nature.

51bis. For nongovernmental organizations working on global health issues, sustained and systematic engagement could include research and active advocacy around WHO meetings and WHO's policies, norms and standards. Official relations may be considered for such nongovernmental organizations based on at least three years of their activities and future work plan on research and advocacy on global public health issues.

52. The Executive Board shall be responsible for deciding on the admission of organizations into official relations with WHO and shall review this status every three years. The Director-General may propose international nongovernmental organizations, philanthropic foundations and international business associations for admission. The Director-General can also propose an earlier review based on the experience in the collaboration with the organization concerned.

53. Entities in official relations are invited to participate in sessions of WHO's governing bodies. This privilege shall include:

- (a) the possibility to appoint a representative to participate, without right of vote, in meetings of WHO's governing bodies or in meetings of the committees and conferences convened under its authority;
- (b) the possibility to make a statement if the Chairman of the meeting (i) invites them to do so or (ii) accedes to their request when an item in which the related entity is particularly interested is being discussed;
- (c) the possibility to submit the statement referred to in subparagraph (b) above in advance of the debate for the Secretariat to post on a dedicated website.

54. Non-State actors participating in WHO governing bodies' meetings shall designate a head of their delegation and declare the affiliations of their delegates. This declaration shall include the function of each delegate within the non-State actor itself and, where applicable, the function of that delegate within any affiliated organization.

55. Regional committees may also decide on a procedure granting accreditation to their meetings to other international, regional, and national¹ non-State actors not in official relations with WHO as long as the procedure is managed in accordance with this framework.

Procedure for admitting and reviewing organizations in official relations

56. The application for admission into official relations shall be based on the up-to-date entries in the WHO register of non-State actors, providing all the necessary information as requested on the non-State actor's nature and activities. The application shall include a summary of past engagement as documented in the register of non-State actors and a three-year plan for collaboration with WHO that has been developed and agreed on jointly by the non-State actor and WHO.

¹ In accordance with WHO Constitution, Article 71.

57. A signed letter certifying the accuracy of the application for official relations submitted online shall reach WHO headquarters no later than the end of the month of July for submission to the Executive Board at its session the following January. Applications for official relations shall be reviewed to ensure that the established criteria and other requirements are fulfilled as set out in this framework. Applications should be transmitted to the Executive Board members by the Secretariat six weeks before the opening of the January session of the Executive Board at which they will be considered.

58. (MOVED TO AFTER P61 AS 61BIS)

59. During the Board's January session, the Programme, Budget and Administration Committee shall consider applications submitted and shall make recommendations to the Board. A representative of an applicant organization may be invited by the Committee to speak before it in connection with that organization's application. Should the applicant organization be considered not to meet the established criteria, and bearing in mind the desirability of ensuring a valuable continuing partnership based on defined objectives and evidenced by a record of successful past engagement and a framework for future collaborative activities, the Committee may recommend postponement of consideration or rejection of an application.

60. The Board, after considering the recommendations of the Committee, shall decide whether an organization is to be admitted into official relations with WHO. A reapplication from a non-State actor shall not normally be considered until two years have elapsed since the Board's decision on the previous application.

61. The Director-General shall inform each organization of the Board's decision on its application. The Director-General shall document decisions taken within the Secretariat and by the Executive Board on applications from non-State actors, reflect this status in the WHO register of non-State actors, and maintain a list of the organizations admitted into official relations.

61bis The entities in official relations and the Secretariat should name focal points for collaboration who are responsible for informing each other and their organizations of any developments in the implementation of the plan for collaboration and who are the first points of contact for any changes or problems.

62. The Board, through its Programme, Budget and Administration Committee, shall review collaboration with each non-State actor in official relations every three years and shall decide on the desirability of maintaining official relations or defer the decision on the review to the following year. The Board's review shall be spread over a three-year period, one third of the entities in official relations being reviewed each year.

63. The Director-General can propose earlier reviews of a non-State actor's official relations with WHO by the Executive Board through its Programme, Budget and Administration Committee in case of issues such as non-fulfilment of the entity's part in the plan of collaboration, lack of contact, failure by the non-State actor to fulfil its reporting requirements or changes in the nature or activities of the organization concerned, the non-State actor ceasing to fulfil the criteria for admission, or any potential new risks for the collaboration.

64. The Board may discontinue official relations if it considers that such relations are no longer appropriate or necessary in the light of changing programmes or other circumstances. Similarly, the Board may suspend or discontinue official relations if an organization no longer meets the criteria that applied at the time of the establishment of such relations, fails to update its information and report on

the collaboration in the WHO register on non-State actors or fails to fulfil its part in the agreed programme of collaboration.

(64 bis: MOVED TO 51 bis)

OVERSIGHT OF ENGAGEMENT

65. The Executive Board, through its Programme, Budget and Administration Committee, oversees the implementation of WHO's framework of engagement with non-State actors, proposes revisions to the framework and can grant the privileges of official relations to international nongovernmental organizations, philanthropic foundations and international business associations.

66. The Programme Budget and Administration Committee shall review, provide guidance and, as appropriate, make recommendations to the Executive Board on:

- (a) oversight of WHO's implementation of the framework of engagement with non-State actors including:
 - (i) consideration of the annual report on engagement with non-State actors submitted by the Director-General
 - (ii) any other matter on engagement referred to the Committee by the Board
- (b) entities in official relations with WHO, including:
 - (i) proposals for admitting non-State actors into official relations
 - (ii) review of renewals of entities in official relations
- (c) any proposal, when needed, for revisions of the framework of engagement with non-State actors.

NON-COMPLIANCE WITH THIS FRAMEWORK

67. Non-compliance can include inter alia the following: significant delays in the provision of information to the WHO register of non-State actors; provision of wrong information; use of the engagement with WHO for purposes other than protecting and promoting public health, such as for commercial, promotional, marketing and advertisement purposes; misuse of WHO's name and emblem; attempt at undue influence; and abuse of the privileges conferred by official relations.

68. Non-compliance by a non-State actor with the provisions of this framework can have consequences for the entity concerned after due process including a reminder, a warning, a cease-and-desist letter, a rejection of renewal of engagement and termination of engagement. The review of the status of official relations by the Executive Board can be anticipated and non-compliance can be the reason for non-renewal of official relations. Except in the case of important and intentional cases of non-compliance the non-State actor concerned should not be automatically excluded from other engagements with WHO.

69. Any financial contribution received by WHO that is subsequently discovered to be non-compliant with the terms of this framework shall be returned to the contributor.

IMPLEMENTATION

69bis. Consistent with the principles identified in paragraph 6, this framework will be implemented in its entirety in a manner that manages and strengthens WHO's engagement with non-State actors towards the attainment of public health objectives, including through multistakeholder partnerships, whilst protecting and preserving WHO's integrity, independence, credibility and reputation;

69ter. The Director-General, in the application of this framework, when responding to acute public health events described in the International Health Regulations (2005) or other emergencies with health consequences, will act according to the WHO Constitution¹ and the principles identified in this framework. In doing so, the Director-General may exercise flexibility as might be needed in the application of the procedures of this framework in those responses, when he/she deems necessary, in accordance with WHO's responsibilities as health cluster lead, and the need to engage quickly and broadly with non-State actors for coordination, scale up and service delivery². The Director-General will inform Member States through appropriate means,³ including in particular written communication, without undue delay when such a response requires exercise of flexibility, and include summary information with justification on the use of such flexibility in the annual report on engagement with non-State actors.

MONITORING AND EVALUATION OF THE FRAMEWORK

70. The implementation of the framework will be constantly monitored internally and by the Executive Board through its Programme, Budget and Administration Committee in the annual report on engagement with non-State actors and the assessment of information available in the register of non-State actors.

71. Furthermore, the implementation of the framework should be periodically evaluated. The results of such evaluation, together with any proposals for revisions of the framework, shall also be submitted to the Executive Board through its Programme, Budget and Administration Committee.

72alt. DELETED

WHO POLICY AND OPERATIONAL PROCEDURES ON ENGAGEMENT WITH NONGOVERNMENTAL ORGANIZATIONS

1. DELETED

2. This policy regulates specifically WHO's engagement with nongovernmental organizations by type of interaction.⁴ The provisions of the overarching framework also apply to all engagements with nongovernmental organizations.

¹ Including Article 2(d) of the WHO Constitution.

² Taking into account resolution WHA65.20 (WHO's response, and role as the health cluster lead, in meeting the growing demands of health in humanitarian emergencies).

³ Including as described in UN General Assembly resolution A/RES/46/182 (Strengthening of the coordination of humanitarian assistance of the United Nations), which establishes the Secretary-General's emergency relief coordinator, and the WHO International Health Regulations (2005).

⁴ See paragraphs 15–21 of the overarching framework for the five types of interaction.

PARTICIPATION

Participation by nongovernmental organizations in WHO meetings¹

3. WHO can invite nongovernmental organizations to participate in consultations, hearings or other meetings in accordance with paragraph 16 of the overarching framework. Consultations and hearings can be electronic or in person.

4. Participation in other meetings is on the basis of discussion of an item in which the nongovernmental organization has a particular interest and where its participation adds value to the deliberations of the meeting. Such participation is for the exchange of information and views, but never for the formulation of advice.

4bis The nature of participation of nongovernmental organizations depends on the type of meeting concerned. The format, modalities, and the participation of nongovernmental organizations in consultations, hearings, and other meetings is decided on a case-by-case basis by the WHO governing bodies or by the Secretariat. Participation and inputs received from nongovernmental organizations shall be made publicly available, wherever possible. Nongovernmental organizations do not take part in any decision-making process of the Organization.

Involvement of the Secretariat in meetings organized by nongovernmental organizations

5. WHO can organize joint meetings, or cosponsor meetings organized by nongovernmental organizations, as long as the integrity, independence and reputation of the Organization are preserved, and as long as this participation furthers WHO's objectives as expressed in the General Programme of Work. WHO staff members may participate in meetings organized by nongovernmental organizations in accordance with the internal rules of the Organization. The nongovernmental organization shall not misrepresent WHO's participation as official WHO support for, or endorsement of, the meeting, and shall agree not to use WHO's participation for promotional purposes.

Specific policies and operational procedures

6. The participation of WHO in meetings organized by nongovernmental organizations as co-organizers, cosponsors, panellists or speakers shall be managed according to the provisions of this Framework.

RESOURCES

7. WHO can accept financial and in-kind contributions from nongovernmental organizations as long as such contributions fall within WHO's General Programme of Work, do not create conflicts of interest, are managed in accordance with the framework, and comply with other relevant regulations, rules and policies of WHO.

7bis The acceptance of contributions (whether in cash or in kind) should be made subject to the following conditions:

- (a) the acceptance of a contribution does not constitute an endorsement by WHO of the nongovernmental organization;

¹ Other than sessions of the governing bodies, which are regulated by the policy on management of engagement.

- (b) the acceptance of a contribution does not confer on the contributor any privilege or advantage;
- (c) the acceptance of a contribution as such does not offer the contributor any possibility for advising, influencing, participating in, or being in command of the management or implementation of operational activities;
- (d) WHO keeps its discretionary right to decline a contribution, without any further explanation.

8. WHO can provide resources to a nongovernmental organization for implementation of particular work in accordance with the Programme Budget, the Financial Regulations and Financial Rules and other applicable rules and policies. The resources concerned can be either for a project of the institution which WHO considers merits support and is consistent with WHO's general programme of work, or for a project organized or coordinated by WHO. The former constitutes a grant, the latter a service.

Specific policies and operational procedures

9. Any acceptance of resources from a nongovernmental organization is handled in accordance with the provisions of this framework and relevant other WHO rules and guidelines such as the Staff Regulations and Staff Rules, the Financial Regulations and Financial Rules and policies governing procurement, as well as WHO's guidelines for medicine donations and WHO's guidelines for health care equipment donations;
10. For reasons of transparency, contributions from nongovernmental organizations must be publicly acknowledged by WHO in accordance with its policies and practices.
11. Acknowledgements shall usually be worded along the following lines: "The World Health Organization gratefully acknowledges the financial contribution of [Nongovernmental organization] towards [description of the outcome or activity]".
12. Contributions received from nongovernmental organizations are listed in the financial report and audited financial statements of WHO as well as the Programme budget web portal and the WHO register of non-State actors.
13. Nongovernmental organizations may not use the fact that they have made a contribution in their materials used for commercial, promotional, marketing and advertisement purposes.¹ However, they may make reference to the contribution in their annual reports or similar documents. In addition, they may mention the contribution on their websites, and in special non-promotional publications, provided that the content and context have been agreed with WHO.

EVIDENCE

14 Nongovernmental organizations may provide their up-to-date information and knowledge on technical issues, and share their experience with WHO, as appropriate, subject to the provisions of the overarching framework, and this specific policy and operational procedures, and other applicable WHO rules, policies and procedures. Such contribution should be made publicly available, as appropriate, wherever possible. Scientific evidence generated should be made publicly available.

¹ In accordance with paragraph 45 of the overarching framework.

ADVOCACY

15. WHO collaborates with nongovernmental organizations on advocacy for health and increasing awareness of health issues; for changing behaviours in the interest of public health; and for fostering collaboration and greater coherence between non-State actors where joint action is required.

16. Nongovernmental organizations are encouraged to disseminate WHO's policies, guidelines, norms and standards and other tools through their networks.

16bis WHO encourages NGOs to implement and advocate for the implementation of WHO's policies, norms and standards. WHO engages in dialogue with NGOs in order to promote the implementation of WHO's policies, norms and standards.¹

16ter Nongovernmental organizations can only collaborate with WHO in advocacy for the implementation of WHO policies norms or standards if they commit themselves to implement these policies, norms or standards in their entirety. No partial or selective implementation is acceptable.

TECHNICAL COLLABORATION

17. WHO may engage with the nongovernmental organizations for technical collaboration as defined in the overarching framework paragraph 21. Technical collaboration with nongovernmental organizations is encouraged. This collaboration must be in the interest of WHO, and managed in accordance with the overarching framework and this policy to protect WHO, and in particular, its normative work, from any undue influence or conflict of interest and to ensure there is no interference with WHO's advisory function to Member States.

WHO POLICY AND OPERATIONAL PROCEDURES ON ENGAGEMENT WITH PRIVATE SECTOR ENTITIES

1. DELETED

2. This policy regulates specifically WHO's engagement with private sector entities by type of interaction.² The provisions of the overarching framework also apply to all engagements with private sector entities.

2bis. When engaging with private sector entities, it should be borne in mind that WHO's activities affect the commercial sector in broader ways, through, among others, its public health guidance, its recommendations on normative standards, or other work that might indirectly or directly influence product costs, market demand, or profitability of specific goods and services.

3. In engaging with private sector entities, WHO will aim to operate on a competitively neutral basis.

¹ Nongovernmental organizations working with WHO will be expected to conform to WHO's public health policies in areas such as food safety, chemical safety, ethical promotion of medicinal drug products, tobacco control, noncommunicable diseases, as well as health and safety at work.

² See paragraphs 15–21 of the overarching framework for the five types of interaction.

PARTICIPATION

Participation by private sector entities in WHO meetings¹

4. WHO can invite private sector entities to participate in consultations, hearings or other meetings in accordance with paragraph 16 of the overarching framework. Consultations and hearings can be electronic or in person.

5. Participation in other meetings is on the basis of discussion of an item in which the private sector entity has a particular interest and where its participation adds value to the deliberations of the meeting. Such participation is for the exchange of information and views, but never for the formulation of advice.

5bis The nature of participation of private sector entities depends on the type of meeting concerned. The format, modalities, and the participation of private sector entities in consultations, hearings, and other meetings is decided on a case-by-case basis by the WHO governing bodies or by the Secretariat. Participation and inputs received from private sector entities shall be made publicly available, wherever possible. Private sector entities do not take part in any decision making process of the Organization.

Involvement of the Secretariat in meetings organized by private sector entities

6. WHO staff members may participate in meetings organized by a private sector entity as long as the integrity, independence and reputation of the Organization are preserved and as long as this participation furthers WHO's objectives as expressed in the General Programme of Work. The private sector entity shall not misrepresent WHO's participation as official WHO support for, or endorsement of, the meeting, and shall agree not to use WHO's participation for commercial and/or promotional purposes.

Specific policies and operational procedures

7. The participation of WHO staff members in meetings of private sector entities as panellists, speakers or in any other capacity shall be managed according to the provisions of the overarching framework and this specific policy.

8. WHO does not cosponsor meetings organized wholly or partly by private sector entities. It may, however, cosponsor a meeting for which the scientific initiators have hired a commercial conference organizer to deal with the logistical aspects, provided that the commercial organizer makes no contribution to the scientific content of the meeting.

9. WHO does not cosponsor meetings organized by other actors where one or more health-related private sector entities are also cosponsors. Other instances of cosponsorship of meetings organized by other actors where non health-related private sector entities are also cosponsors should be reviewed on a case-by-case basis and are subject to the provisions of this framework.

10. There shall be no commercial exhibitions on WHO premises and at WHO's meetings.

¹ Other than sessions of the governing bodies, which are regulated by the policy on management of engagement.

11. WHO does not cosponsor commercial exhibitions, whether as part of meetings organized by private sector entities or as part of meetings organized by other actors.

RESOURCES

12. The level of risk associated with the acceptance of resources from private sector entities depends on the field of activity of the private sector entity, the WHO activity for which the resources are used and the modalities of the contributions.

(a) Financial contributions may be accepted from private sector entities whose business is unrelated to that of WHO, provided they are not engaged in any activity or have close ties with any entity that is incompatible with WHO's mandate and work.

(b) Financial contributions may not be sought or accepted from private sector entities that have, themselves or through their affiliated companies, a direct commercial interest in the outcome of the project toward which they would be contributing, unless approved in conformity with the provisions for clinical trials or product development (see paragraph 38 below).

(b)bis The provisions set out in paragraph 12(b) shall be without prejudice to specific mechanisms, such as the PIP Framework, set up by the Health Assembly that involve the receipt and pooling of resources.¹

(c) Caution should be exercised in accepting financial contributions from private sector entities that have even an indirect interest in the outcome of the project (i.e. the activity is related to the entities' field of interest, without there being a conflict as referred to above). In such an event, other commercial enterprises having a similar indirect interest should be invited to contribute, and the reason clearly described if this does not prove possible. The larger the proportion of the contribution from any one source, the greater the care that should be taken to avoid the possibility of a conflict of interest or appearance of an inappropriate association with one contributor.

13. Financial and in-kind contributions from private sector entities to WHO's programmes are only acceptable in the following conditions:

(a) the contribution is not used for normative work;

(b) if a contribution is used for activities other than normative work in which the private sector entity could have a commercial interest, the public health benefit of the engagement needs clearly to outweigh its potential risks;

(c) the proportion of funding of any activity coming from the private sector cannot be such that the programme's continuation would become dependent on this support;

(d) the acceptance of the contribution does not constitute an endorsement by WHO of the private sector entity, or its activities, products or services;

(e) the contributor may not use the results of WHO's work for commercial purposes or use the fact of its contribution in its promotional material;

¹ In accordance with paragraph 18 of the overarching framework.

- (f) the acceptance of the contribution does not afford the contributor any privilege or advantage;
- (g) the acceptance of the contribution does not offer the contributor any possibility for advising, influencing, participating in, or being in command of the management or implementation of operational activities;
- (h) WHO keeps its discretionary right to decline a contribution, without any further explanation.

14. [DELETED]

15. Any acceptance of resources from private sector entities is handled in accordance with the provisions of this framework and relevant other WHO rules and guidelines such as the Staff Regulations and Staff Rules, the Financial Regulations and Financial Rules and policies governing procurement, as well as WHO's guidelines for medicine donations and WHO's guidelines for health care equipment donations;

16. For reasons of transparency, contributions from private sector entities must be publicly acknowledged by WHO in accordance with its policies and practices.

17. Acknowledgements shall usually be worded along the following lines: "The World Health Organization gratefully acknowledges the financial contribution of [Private sector entity] towards [description of the outcome or activity]".

18. Contributions received from private sector entities, are listed in the financial report and audited financial statements of WHO as well as the Programme budget web portal and the register of non-State actors.

19. Private sector entities may not use the fact that they have made a contribution in their materials used for commercial, promotional, marketing and advertisement purposes.¹ However, they may make reference to the contribution in their annual reports or similar documents. In addition, they may mention the contribution on their websites, and in special non-promotional publications, provided that the content and context have been agreed with WHO.

Donations of medicines and other health technologies²

20. In determining the acceptability of large-scale donations of medicines and other health-related products, the following criteria should be met.

- (a) Sound evidence exists of the safety and efficacy of the product in the indication for which it is being donated. The product is approved or otherwise authorized by the recipient country for use in that indication; it should also preferably appear in the WHO Model List of Essential Medicines for that indication.

¹ In accordance with paragraph 45 of the overarching framework.

² Such donations shall be in line with interagency guidelines: World Health Organization, Ecumenical Pharmaceutical Network, International Pharmaceutical Federation, International Federation of Red Cross and Red Crescent Societies, International Health Partners, The Partnership for Quality Medical Donations, et al. Guidelines for medicine donations – revised 2010. Geneva: World Health Organization; 2011.

- (b) Objective and justifiable criteria for the selection of recipient countries, communities or patients have been determined. In emergency situations, flexibilities may be required.
- (c) A supply system is in place and consideration is given to means of preventing waste, theft and misuse (including leakage back into the market).
- (d) A training and supervision programme is in place for all personnel involved in the efficient administration of supply, storage and distribution at every point from the donor to the end-user.
- (e) A donation of medicines and other health-related products is not of a promotional nature, either with regard to the company itself or insofar as it creates a demand for the products that is not sustainable once the donation has ended.
- (f) WHO does not accept products at the end of their shelf life.
- (g) A phase-out plan for the donation has been agreed upon with recipient countries.
- (h) A system for monitoring adverse reactions to the product has been set up with the participation of the donating company.

21. In consultation with the department responsible for financial matters in WHO, the value of donations of medicines and other health-related products is determined and is formally recorded in the audited statements and the WHO register of non-State actors.

Financial contributions for clinical trials

22. Except as provided in paragraph 38 below on product development, financial contributions from a private sector entity for a clinical trial arranged by WHO on that company's proprietary product are considered on a case-by-case basis. In this connection, it should be ensured that:

- (a) the research or development activity is of public health importance;
- (b) the research is conducted at WHO's request and potential conflicts of interest are managed;
- (c) WHO only accepts such financial contributions, if the research would not take place without WHO's involvement or if WHO's involvement is necessary in order to ensure that the research is undertaken in conformity with internationally accepted technical and ethical standards and guidelines.

23. If the above-mentioned requirements are met, a financial contribution may be accepted from a company having a direct commercial interest in the trial in question, provided that appropriate mechanisms are put in place to ensure that WHO controls the conduct and the dissemination of the outcomes of the trials, including the content of any resulting publication, and that the trial results are free from any inappropriate influence or perceived influence from the company concerned.

Contributions for WHO meetings

24. For meetings convened by WHO, a contribution from a private sector entity may not be accepted if it is designated to support the participation of specific invitees (including such invitees' travel and accommodation), regardless of whether such contribution would be provided directly to the participants or channelled through WHO.

25. Contributions may be accepted to support the overall costs of a meeting.
26. WHO receptions and similar functions shall not be paid for by private sector entities.

Contributions for WHO staff participating in external meetings

27. An external meeting is one convened by a party other than WHO. Support from private sector entities for travel of WHO staff members to attend external meetings or conferences may fall into two categories:

- (a) meetings held by the private sector entity paying for travel: financing for travel may be accepted in accordance with WHO's rules if the private sector entity is also supporting the travel and ancillary expenses of other participants in the meeting, and the risk of a conflict of interest has been assessed and managed;
- (b) meetings held by a third party (i.e. a party other than the private sector entity proposing to pay for the travel): financing for travel may not be accepted from a private sector entity.

Contributions for publications

28. Financial contributions may be accepted from private sector entities for meeting the printing costs of WHO publications, as long as no conflict of interest arises. In no event may commercial advertisements be placed in WHO publications;

29. DELETED

Cost recovery

30. In cases where a WHO evaluation scheme is in place (i.e. to evaluate certain products, processes or services against official WHO guidelines), the Organization may charge private sector entities for such services on the basis of cost recovery. The purpose of WHO's evaluation schemes is always to provide advice to governments and/or international organizations for procurement. Evaluation does not constitute endorsement by WHO of the product(s), process or service in question.

EVIDENCE

31. Private sector entities may provide their up-to-date information and knowledge on technical issues, and share their experience with WHO, as appropriate, subject to the provisions of the overarching framework, and this specific policy and operational procedures, and other applicable WHO rules, policies and procedures. Such contribution should be made publicly available, as appropriate, wherever possible. Scientific evidence generated should be made publicly available.

32. DELETED

ADVOCACY

33. WHO encourages private sector entities to implement and advocate for the implementation of WHO's policies, norms and standards. WHO engages in dialogue with private sector entities in order to promote the implementation of WHO's policies, norms and standards.¹

34. Private sector entities can only collaborate with WHO in advocacy for the implementation of WHO policies norms or standards if they commit themselves to implement these policies, norms or standards in their entirety. No partial or selective implementation is acceptable.

35. International business associations are encouraged to work with their members in order to improve their public health impact and the implementation of WHO policies, norms and standards.

TECHNICAL COLLABORATION

36. WHO may engage with the private sector for technical collaboration as defined in the overarching framework paragraph 21. Technical collaboration with private sector entities is encouraged. This collaboration must be in the interest of WHO, and managed in accordance with the overarching framework and this policy to protect WHO, and in particular, its normative work, from any undue influence or conflict of interest and to ensure there is no interference with WHO's advisory function to Member States.

Specific policies and operational procedures

37. If WHO has drawn up official specifications for a product, it may provide technical advice to manufacturers for development of their product in accordance with these specifications, provided that all private sector entities known to have an interest in such a product are given the opportunity to collaborate with WHO in the same way.

38. WHO may collaborate with private sector entities in the research and development of health related technologies that contribute to increasing access to quality, safe, efficacious and affordable medical products. Collaborative research and development should, as a general rule, be undertaken only if WHO and the private sector entity have concluded an agreement which ensures that the final product will ultimately be widely available, including to the public sector of developing countries at a preferential price. If such an agreement is concluded, financing may be accepted from the private sector entity for a trial arranged by WHO on the product in question, on the basis that contractual commitments obtained from the private sector entity outweigh any potential conflict of interest in accepting such financing.

WHO POLICY AND OPERATIONAL PROCEDURES ON ENGAGEMENT WITH PHILANTHROPIC FOUNDATIONS

1. DELETED

¹ Private sector entities working with WHO will be expected to conform to WHO's public health policies in areas such as food safety, chemical safety, ethical promotion of medicinal drug products, tobacco control, noncommunicable diseases, as well as health and safety at work.

2. This policy regulates specifically WHO's engagement with philanthropic foundations by type of interaction.¹ The provisions of the overarching framework also apply to all engagements with philanthropic foundations.

PARTICIPATION

Participation by philanthropic foundations in WHO meetings²

3. WHO can invite philanthropic foundations to participate in consultations, hearings or other meetings in accordance with paragraph 16 of the overarching framework. Consultations and hearings can be electronic or in person.

4. Participation in other meetings is on the basis of discussion of an item in which the philanthropic foundation has a particular interest and where its participation adds value to the deliberations of the meeting. Such participation is for the exchange of information and views, but never for the formulation of advice.

4bis The nature of participation of philanthropic foundations depends on the type of meeting concerned. The format, modalities, and the participation of philanthropic foundations in consultations, hearings, and other meetings is decided on a case-by-case basis by the WHO governing bodies or by the Secretariat. Participation and inputs received from philanthropic foundations shall be made publicly available, wherever possible. Philanthropic foundations do not take part in any decision making process of the Organization.

Involvement of the Secretariat in meetings organized by philanthropic foundations

5. WHO can organize joint meetings, or cosponsor meetings organized by philanthropic foundations, as long as the integrity, independence and reputation of the Organization are preserved, and as long as this participation furthers WHO's objectives as expressed in the General Programme of Work. WHO staff members may participate in meetings organized by philanthropic foundations in accordance with the Organization's internal rules. The philanthropic foundations shall not misrepresent WHO's participation as official WHO support for, or endorsement of, the meeting, and shall agree not to use WHO's participation for promotional purposes.

Specific policies and operational procedures

6. The participation of WHO in meetings organized by philanthropic foundations as co-organizers, cosponsors, panellists or speakers shall be managed according to the provisions of the framework for engagement with non-State actors.

RESOURCES

7. WHO can accept financial and in-kind contributions from philanthropic foundations as long as such contributions fall within WHO's General Programme of Work, do not create conflicts of interest, are managed in accordance with the framework, and comply with other relevant regulations, rules and policies of WHO.

¹ See paragraphs 15–21 of the overarching framework for the five types of interaction.

² Other than sessions of the governing bodies, which are regulated by the policy on management of engagement.

8. As for all contributors, philanthropic foundations shall align their contributions to the priorities set by the Health Assembly in the approved Programme budget.
9. Philanthropic foundations are invited to participate in the financing dialogue, which is designed to improve the alignment, predictability, flexibility and transparency of WHO's funding and to reduce budgetary vulnerability.
10. WHO's programmes and offices should strive to ensure that they do not depend on one single source of funding.
11. The acceptance of contributions (whether in cash or in kind) should be made subject to the following conditions:
 - (a) the acceptance of a contribution does not constitute an endorsement by WHO of the philanthropic foundation;
 - (b) the acceptance of a contribution does not confer on the contributor any privilege or advantage;
 - (c) the acceptance of a contribution as such does not offer the contributor any possibility for advising, influencing, participating in, or being in command of the management or implementation of operational activities;
 - (d) WHO keeps its discretionary right to decline a contribution, without any further explanation.

Specific policies and operational procedures

12. Any acceptance of resources from a philanthropic foundation is handled in accordance with the provisions of this framework and relevant other WHO rules and guidelines such as the Staff Regulations and Staff Rules, the Financial Regulations and Financial Rules and policies governing procurement, as well as WHO's guidelines for medicine donations and WHO's guidelines for health care equipment donations.
13. For reasons of transparency, contributions from philanthropic foundations must be publicly acknowledged by WHO in accordance with its policies and practices.
14. Acknowledgements shall usually be worded along the following lines: "The World Health Organization gratefully acknowledges the financial contribution of [Philanthropic foundation] towards [description of the outcome or activity]".
15. Contributions received from philanthropic foundations are listed in the financial report and audited financial statements of WHO as well as the Programme budget web portal and the WHO register of non-State actors.
16. Philanthropic foundations may not use the fact that they have made a contribution in their materials used for commercial, promotional, marketing and advertisement purposes.¹ However, they may make reference to the contribution in their annual reports or similar documents. In addition, they

¹ In accordance with paragraph 45 of the overarching framework.

may mention the contribution on their websites, and in special non-promotional publications, provided that the content and context have been agreed with WHO.

EVIDENCE

17. Philanthropic foundations may provide their up-to-date information and knowledge on technical issues, and share their experience with WHO, as appropriate, subject to the provisions of the overarching framework, and this specific policy and operational procedures, and other applicable WHO rules, policies and procedures. Such contribution should be made publicly available, as appropriate, wherever possible. Scientific evidence generated should be made publicly available.

ADVOCACY

18. WHO collaborates with philanthropic foundations on advocacy for health and increasing awareness of health issues; for changing behaviours in the interest of public health; and for fostering collaboration and greater coherence between non-State actors where joint action is required. Philanthropic foundations are encouraged to disseminate WHO's policies, guidelines, norms and standards and other tools through their networks so as to extend WHO's own reach.

18bis WHO encourages Philanthropic foundations to implement and advocate for the implementation of WHO's policies, norms and standards. WHO engages in dialogue with Philanthropic foundations in order to promote the implementation of WHO's policies, norms and standards.¹

18ter Philanthropic foundations can only collaborate with WHO in advocacy for the implementation of WHO policies norms or standards if they commit themselves to implement these policies, norms or standards in their entirety. No partial or selective implementation is acceptable.

TECHNICAL COLLABORATION

19. WHO may engage with the philanthropic foundations for technical collaboration as defined in the overarching framework paragraph 21. Technical collaboration with philanthropic foundations is encouraged. This collaboration must be in the interest of WHO, and managed in accordance with the overarching framework and this policy to protect WHO, and in particular, its normative work, from any undue influence or conflict of interest and to ensure there is no interference with WHO's advisory function to Member States).

WHO POLICY AND OPERATIONAL PROCEDURES ON ENGAGEMENT WITH ACADEMIC INSTITUTIONS

1. DELETED

2. This policy regulates specifically WHO's engagement with academic institutions by type of interaction.² The provisions of the overarching framework also apply to all engagements with academic institutions.

¹ Philanthropic foundations working with WHO will be expected to conform to WHO's public health policies in areas such as food safety, chemical safety, ethical promotion of medicinal drug products, tobacco control, noncommunicable diseases, as well as health and safety at work.

² See paragraphs 15–21 of the overarching framework for the five types of interaction.

3. The engagement with academic institutions at the institutional level has to be distinguished from the collaboration with individual experts working for academic institutions.

PARTICIPATION

Participation by academic institutions in WHO meetings

4. WHO can invite academic institutions to participate in consultations, hearings or other meetings in accordance with paragraph 16 of the overarching framework. Consultations and hearings can be electronic or in person.

5. Participation in other meetings is on the basis of discussion of an item in which the academic institution has a particular interest and where its participation adds value to the deliberations of the meeting. Such participation is for the exchange of information and views, but never for the formulation of advice.

5bis The nature of participation of academic institution depends on the type of meeting concerned. The format, modalities, and the participation of academic institution in consultations, hearings, and other meetings is decided on a case-by-case basis by the WHO governing bodies or by the Secretariat. Participation and inputs received from academic institutions shall be made publicly available, wherever possible. Academic institutions do not take part in any decision-making process of the Organization.

Involvement of the Secretariat in meetings organized by academic institutions

6. WHO can organize joint meetings, or cosponsor meetings organized by academic institutions, as long as the integrity, independence and reputation of the Organization are preserved, and as long as this participation furthers WHO's objectives as expressed in the General Programme of Work. WHO staff members may participate in meetings organized by academic institutions in accordance with the Organization's internal rules. The academic institution shall not misrepresent WHO's participation as official WHO support for, or endorsement of, the meeting, and shall agree not to use WHO's participation for promotional purposes.

Specific policies and operational procedures

7. The participation of WHO in meetings organized by academic institutions as co-organizers, cosponsors, panellists or speakers shall be managed according to the provisions of this framework.

RESOURCES

8. WHO can accept financial and in-kind contributions from academic institutions as long as such contributions fall within WHO's General Programme of Work, do not create conflicts of interest, are managed in accordance with the framework, and comply with other relevant regulations, rules and policies of WHO.

9. WHO can provide resources to an academic institution for implementation of particular work (such as research, a clinical trial, laboratory work and preparation of a document), in accordance with the Financial Regulations and Financial Rules and other applicable rules and policies. This can be either for a project of the institution which WHO considers merits support, based on a clear public health interest, and is consistent with WHO's General Programme of Work, or for a project organized or coordinated by WHO. The former constitutes a grant, the latter a service.

Specific policies and operational procedures

10. Any acceptance of resources from an academic institution is handled in accordance with the provisions of this framework and relevant other WHO rules and guidelines such as the Staff Regulations and Staff Rules, the Financial Regulations and Financial Rules and policies governing procurement, as well as WHO's guidelines for medicine donations and WHO's guidelines for health care equipment donations;
11. For reasons of transparency, contributions from academic institutions must be publicly acknowledged by WHO in accordance with its policies and practices.
12. Acknowledgements shall usually be worded along the following lines: "The World Health Organization gratefully acknowledges the financial contribution of [academic institution] towards [description of the outcome or activity]".
13. Contributions received from academic institutions are listed in the financial report and audited financial statements of WHO as well as the Programme budget web portal and the WHO register of non-State actors.
14. Academic institutions may not use the fact that they have made a contribution in their materials used for commercial, promotional, marketing and advertisement purposes.¹ However, they may make reference to the contribution in their annual reports or similar documents. In addition, they may mention the contribution on their websites, and in special non-promotional publications, provided that the content and context have been agreed with WHO.

EVIDENCE

15. Academic institutions may provide their up-to-date information and knowledge on technical issues, and share their experience with WHO, as appropriate, subject to the provisions of the overarching framework, and this specific policy and operational procedures, and other applicable WHO rules, policies and procedures. Such contribution should be made publicly available, as appropriate, wherever possible. Scientific evidence generated should be made publicly available.
16. Intellectual property arising from collaborations with academic institutions is regulated by the agreement with the academic institution. This should be addressed in consultation with the Office of the Legal Counsel.

ADVOCACY

17. WHO collaborates with academic institutions on advocacy for health and increasing awareness of health issues; for changing behaviours in the interest of public health; and for fostering collaboration and greater coherence between non-State actors where joint action is required. Academic institutions are encouraged to disseminate WHO's policies, guidelines, norms and standards and other tools through their networks so as to extend WHO's own reach.

¹ In accordance with paragraph 45 of the overarching framework.

17bis WHO encourages academic institutions to implement and advocate for the implementation of WHO's policies, norms and standards. WHO engages in dialogue with academic institutions in order to promote the implementation of WHO's policies, norms and standards.¹

17ter Academic institutions can only collaborate with WHO in advocacy for the implementation of WHO policies norms or standards if they commit themselves to implement these policies, norms or standards in their entirety. No partial or selective implementation is acceptable.

TECHNICAL COLLABORATION

18. WHO may engage with academic institutions for technical collaboration as defined in the overarching framework paragraph 21. Technical collaboration with academic institutions is encouraged. This collaboration must be in the interest of WHO, and managed in accordance with the overarching framework and this policy to protect WHO, and in particular, its normative work, from any undue influence or conflict of interest and to ensure there is no interference with WHO's advisory function to Member States.

19. Scientific collaborations are regulated by the Regulations for Study and Scientific Groups, Collaborating Institutions and other Mechanisms of Collaboration.²

20. Academic institutions or parts thereof can be designated as WHO collaborating centres in accordance with the Regulations mentioned above. In this context, before granting the status of WHO collaborating centre a due diligence and risk assessment in accordance with this framework is conducted. The collaboration with these collaborating centres is regulated by the aforementioned regulations and reflected in the register of non-State actors.

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

Resolution: Framework of engagement with non-State actors (FENSA)	
A. Link to the general programme of work and the programme budget	
1.	Please indicate to which impact and outcome in the Twelfth General Programme of Work, 2014–2019 and which output in the Programme budget 2016–2017 this draft resolution will contribute if adopted. Twelfth General Programme of Work outcome 6. Programme budget output 6.1.2.
2.	If there is no link to the results as indicated in the Twelfth General Programme of Work, 2014–2019 and the Programme budget 2016–2017, please provide a justification for giving consideration to the draft resolution. Not applicable.

¹ Academic institutions working with WHO will be expected to conform to WHO's public health policies in areas such as food safety, chemical safety, ethical promotion of medicinal drug products, tobacco control, noncommunicable diseases, as well as health and safety at work.

² Basic documents, 48th ed. Geneva: World Health Organization; 2014: pp.131–138.

3. What is the proposed timeline for implementation of this resolution?

Implementation will begin in 2016.

If the timeline stretches to future programme budgets, please ensure that further information is provided in the costing section.

B. Budgetary implications of implementation of the resolution**1. Current biennium: estimated budgetary requirements, in US\$ million**

Level	Staff	Activities	Total
Country offices	2.8	0	2.8
Regional offices	2.8	0	2.8
Headquarters	7.0	1.6	8.6
Total	12.6	1.6	14.2

1(a) Is the estimated budget requirement in respect of implementation of the resolution fully included within the current programme budget? (Yes/No)

Yes.

However, the resolution calls for new work that was not anticipated when the Programme budget 2016–2017 was developed and approved.

1(b) Financing implications for the budget in the current biennium:**– How much is financed in the current biennium?**

US\$ 7.5 million

– What are the gaps?

US\$ 6.7 million

– What action is proposed to close these gaps?

The gap will be addressed through coordinated resource mobilization efforts for possible financing by voluntary contribution.

2. Next biennium: estimated budgetary requirements, in US\$ million

Level	Staff	Activities	Total
Country offices	2.8	0	2.8
Regional offices	2.8	0	2.8
Headquarters	7.0	0	7.0
Total	12.6	0	12.6

2(a) Financing implications for the budget in the next biennium:**– How much is currently financed in the next biennium? 0****– What are the financing gaps?**

US\$ 12.6 million

– What action is proposed to close these gaps?

The costs of implementation will be included in the Programme budget 2018–2019 and financed from flexible funds allocated to Category 6.

The representative of ARGENTINA, speaking in his capacity as Chair of the Open-ended Intergovernmental Meeting on the draft framework of engagement with non-State actors, said that he was pleased to report that, after lengthy discussions, the drafting group had reached a consensus text on the overarching framework of engagement with non-State actors set out in an annex to the draft resolution. Transparency and the inclusion of all participants had constituted prerequisites for building confidence, as had mutual respect and consideration. Every single suggestion had been duly considered and the principle of consensus had been rigorously respected. The negotiation process had been one of the longest in WHO's history and a great learning experience. It had shown that dialogue and a readiness to listen to others promoted greater mutual understanding, which made it possible to find common ground and reach compromise. He thanked the Secretariat for its assistance and praised WHO's efforts to discharge its mandate.

The representative of AUSTRALIA praised the extraordinary efforts of the Chair of the drafting group in delivering consensus on an important aspect of WHO's governance reform agenda.

The representative of ALGERIA, speaking behalf of the Member States of the African Region, said that WHO and all Member States could be proud of the innovative framework, the first of its kind in the United Nations system. The representatives of the African Region had worked tirelessly throughout the long process and he was confident that the outcome would enable WHO to achieve better results in its work. Implementation would not be easy, which was why periodic evaluations were planned to manage areas likely to present difficulty. He called for the adoption of the framework and invited all parties concerned to make every effort to ensure its speedy implementation.

The representative of SOUTH AFRICA said that WHO's engagement with stakeholders should take place within specified parameters. Furthermore, questions relating to the management of risk and conflicts of interest had to be addressed to ensure WHO's credibility. Greater transparency about WHO's engagement would ensure positive perceptions about its integrity. WHO had again taken the lead among organizations of the United Nations system, and she supported adoption of the framework.

The representative of the NETHERLANDS, speaking on behalf of the European Union and its Member States, said that strengthened multisectoral and multistakeholder cooperation was crucial for implementation of the 2030 Agenda for Sustainable Development. He outlined a number of principles that the European Union considered essential for improving the rules governing WHO's engagement with non-State actors: WHO had to be able to engage with a large variety of different actors; any risks had to be managed appropriately; the workload had to be in proportion to the risks and benefits of engagement; the framework had to be applied in all regions and at all levels of the Organization; and WHO should not be prevented from performing its duties to protect and promote health, including in emergency situations. He supported the draft resolution.

The representative of the UNITED KINGDOM OF GREAT BRITAIN AND NORTHERN IRELAND supported the draft resolution and framework.

The representative of BRAZIL welcomed the framework, which was the first of its kind in the United Nations system. He was pleased that all possibilities for engagement were addressed and that emergency situations had been taken into account so as not to hamper WHO's capacity to respond promptly.

The representative of CANADA said that the framework would encourage and broaden WHO's engagement and collaboration with non-State actors, and she looked forward to its implementation at all three levels of WHO. She said that Canada was pleased to sponsor the draft resolution.

The representative of the UNITED STATES OF AMERICA said that the framework would contribute to WHO's engagement in the era of the 2030 Agenda, given the need for multistakeholder partnerships with non-State actors within a context of robust and unbiased risk management processes.

The representative of SWITZERLAND said that the framework would enable WHO to engage more with non-State actors, while managing the risks inherent in such engagement. She was confident that the Secretariat would implement the framework without compromising its integrity, independence, credibility and reputation.

The representative of SPAIN said that he was confident that the framework would not only permit improved engagement with non-State actors, but also help to dispel any doubts or questions about WHO's reputation. Its implementation would be monitored closely by various WHO bodies, including the Programme, Budget and Administration Committee of the Executive Board. Member States should consider whether that Committee should meet more often and not so close in time to the meetings of the governing bodies.

The representative of THAILAND welcomed the framework, which would help to bring about positive collaboration between WHO and non-State actors, and supported the approval of the draft resolution.

The representative of ECUADOR, speaking on behalf of the Region of the Americas, recognized the framework as a significant advance in the overall process of WHO reform and as a policy framework ensuring transparency, accountability, coherence and consistency in the application and treatment of engagement with all non-State actors at all levels of the Organization. The framework and the four specific policies constituted a principled, clear and transparent set of rules for the management of conflicts of interest, while at the same time giving the Secretariat the necessary flexibility to carry out the core functions of WHO. She reiterated the full political commitment of the Region of the Americas to the consistent and coherent implementation of the framework and to its review by the governing bodies.

The representative of MEXICO said that the framework, whose implementation would be constantly monitored, represented significant progress in WHO reform, which had to be based on accountability and transparency.

The representative of COLOMBIA expressed the hope that the framework would provide a sound foundation for engagement with non-State actors. It constituted a step forward in WHO reform and gave the Secretariat very clear guidelines. She fully supported the approval of the draft resolution.

The representative of ESTONIA, speaking on behalf of the Member States of the European Region, said that the framework, which he fully supported, was related to every single item on the agenda, and its importance could not be overestimated. He welcomed the draft resolution.

The representative of INDIA noted that WHO had been engaging with non-State actors without a framework. The purpose of the framework was not to encourage or discourage such engagement, but rather to create a robust framework that ensured transparency, accountability and consistency and the effective management of conflict of interest, so as to protect WHO's integrity and credibility. The framework should be applied as a risk management tool across all three levels of the Organization.

The representative of the RUSSIAN FEDERATION noted with satisfaction that WHO now had a useful instrument for risk management concerning its engagement with non-State actors.

The representative of MALTA said that, as a result of adjustments made since the previous Health Assembly, including at the request of his country, the framework ensured transparency, guaranteed WHO's independence and preserved the Organization's good name. It also balanced the risks and benefits with the resources required for implementation, without impinging on WHO's work at all levels, including in emergencies. With the financial and operational implications now available, the Health Assembly was in a position to take a truly informed decision on the framework, and he welcomed its adoption.

The representative of CHINA said the framework was an important and solid step towards governance reform of WHO, and should be implemented at all three levels of the Organization. She supported the draft resolution.

The representative of GUATEMALA welcomed the framework and praised the skilful efforts of the Chair of the drafting group.

The representative of INDONESIA said that the framework should be implemented consistently, transparently and comprehensively to advance public health and strengthen the integrity, credibility, independence and reputation of WHO. Member States should play a pivotal role in monitoring and evaluating WHO's engagement with non-State actors.

The representative of TIMOR-LESTE welcomed the progress made towards consensus on the framework, but emphasized that any such engagement should: demonstrate a clear public health benefit; be in line with the Constitution, mandate and general programme of work of WHO; respect WHO's intergovernmental nature and the decision-making authority of Member States; support and enhance the scientific and evidence-based approach of WHO's work; and protect WHO from any influence, in particular in determining and applying policies, norms and standards. He endorsed the draft resolution.

The representative of the INTERNATIONAL DIABETES FEDERATION, speaking at the invitation of the CHAIRMAN, congratulated Member States for developing the long-awaited framework of engagement with non-State actors, and expressed support for the draft resolution. The framework should allow WHO to engage effectively with partners, while protecting its policies, norms and standards from undue influence and conflicts of interest. Inclusion in the framework of a reference to the negative impact of policies or activities of non-State actors on efforts to combat noncommunicable diseases was welcome. She was also pleased to note that consideration had been given to secondments from nongovernmental organizations and academic institutions, and looked forward to the development of the associated set of criteria and principles. She looked forward to working with WHO under the new framework.

The representative of the INTERNATIONAL FEDERATION OF MEDICAL STUDENTS' ASSOCIATIONS, speaking at the invitation of the CHAIRMAN, appreciated the opportunities currently made available by WHO to enable non-State actors to contribute to the improvement of global health. She recognized the ongoing reform process and the concerted efforts made to maintain the integrity, independence and credibility of WHO. WHO should exercise caution with respect to private sector engagement, given the potential for such partnerships to unduly influence the Organization's work and priority-setting. Noting the need for inclusivity, she called for engagement with young people.

The representative of the INTERNATIONAL PHARMACEUTICAL FEDERATION, speaking at the invitation of the CHAIRMAN, welcomed the development of the framework, but expressed disappointment that the additional benefits and status accorded to nongovernmental organizations in official relations with WHO were modest compared with those accorded to organizations that were not

in such relations. For the sake of transparency, non-State actors should also be given electronic access to the summary report on due diligence of each non-State actor. The effectiveness and impact of the framework should be periodically assessed through a public, independent report, and could include a set of recommendations to the governing bodies. She reaffirmed the Federation's interest in engaging with WHO to effectively advance and promote public health at the global level.

The representative of MEDICUS MUNDI INTERNATIONAL – INTERNATIONAL ORGANISATION FOR COOPERATION IN HEALTH CARE, speaking at the invitation of the CHAIRMAN, welcomed the agreement concerning secondments by private sector actors and the possibility of reclassifying non-State actors subjected to the influence of the private sector. However, some issues remained a concern. The private sector must not be involved in the setting of policies, norms and standards, and salaries of WHO staff should never be drawn from private sector resources. Furthermore, the private sector should be excluded from the field of capacity building. The discretionary powers vested in the Secretariat should be used in a transparent and judicious manner to protect WHO from undue influence.

The representative of the INTERNATIONAL BABY FOOD ACTION NETWORK, speaking at the invitation of the CHAIRMAN, said the framework and draft resolution did not address the crucial objective of strengthening the involvement of public-interest actors, but instead opened channels for potential undue influence by the corporate and philanthropic sectors. Indeed, the framework failed to recognize the profoundly different nature of non-State actors and private sector entities. She expressed concern that the draft resolution did not call for the development of comprehensive safeguards to protect against conflicts of interest. In addition, by allowing business-interest groups to enter into “official relations” with WHO, the framework would legitimize lobbying by business associations and philanthropic foundations at the meetings of the governing bodies, thereby normalizing their inclusion in public health decision-making.

The representative of the INTERNATIONAL FEDERATION OF PHARMACEUTICAL MANUFACTURERS AND ASSOCIATIONS, speaking at the invitation of the CHAIRMAN, said that the current framework of engagement with non-State actors appeared to be restrictive in a number of areas and could hamper the ability of non-State actors to contribute fully to global health outcomes. The provisions of the framework should be applied equitably across different categories of non-State actors and any conflict of interest that might arise should be managed in a robust, transparent and equitable manner. Noting the importance of transparent engagement and accountability, he said that the introduction of flexibilities would be useful to mitigate unintended consequences and provide for exceptions necessitated by emergency situations.

The representative of STICHTING HEALTH ACTION INTERNATIONAL, speaking at the invitation of the CHAIRMAN, trusted that the procedures for the accreditation of groups in “official relations” with WHO would be made easier for public-interest nongovernmental organizations. While he was pleased that secondments from private sector entities had been prohibited, it was regrettable that the proposal to develop a comprehensive conflict of interest policy had not been reflected in the framework. He favoured the classification of non-State actors into four groups but considered that the approach concerning philanthropic foundations deserved more attention, since the largest global philanthropic donor was perceived to wield extraordinary influence over the Organization.

The DIRECTOR-GENERAL thanked all Member States for their extraordinary efforts over many months. The timely conclusion of the framework of engagement with non-State actors was critical for WHO's leadership in global health. The Organization would be mindful to work with partners to support countries in their full implementation of the Sustainable Development Goals, while making particular efforts to avoid any conflicts of interest. She expressed her deep gratitude to the Chair of the Open-ended Intergovernmental Meeting for his leadership and patience.

Together with the Regional Directors, she was committed to commencing the immediate implementation of the framework, as Member States had requested. She wished to take the opportunity to thank all the staff of WHO, both at headquarters and in the regions, for their continued support and diligent work.

The CHAIRMAN, on behalf of the Committee, thanked the Chair of the Open-ended Intergovernmental Meeting for his work. He took it that the Committee wished to approve the draft resolution on the framework of engagement with non-State actors.

The draft resolution was approved.¹

2. PREPAREDNESS, SURVEILLANCE AND RESPONSE: Item 14 of the agenda (continued)

Implementation of the International Health Regulations (2005): Item 14.1 of the agenda (continued)

- **Report of the Review Committee on the Role of the International Health Regulations (2005) in the Ebola Outbreak and Response** (documents A69/21, A69/21 Add.1 Rev.1 and A69/21 Add.2) (continued from the fourth meeting, section 2))

The CHAIRMAN drew attention to a revised version of the draft decision, contained in document A69/21 Add.1 Rev.1.

The representative of the RUSSIAN FEDERATION expressed support for the draft decision and his Government's willingness to participate in the technical consultations. He trusted that the final version of the global implementation plan would be considered not only by the Executive Board at its 140th session but also by the Seventieth World Health Assembly.

The EXECUTIVE DIRECTOR ad interim (Outbreaks and Health Emergencies) thanked the many Member State representatives who had worked on the draft decision and contributed to the wording. He emphasized that representatives from all Member States were invited to participate in the technical discussions referred to in paragraph (2) of the draft decision.

The draft decision was approved.²

¹ Transmitted to the Health Assembly in the Committee's fifth report and adopted as resolution WHA69.10.

² Transmitted to the Health Assembly in the Committee's fifth report and adopted as decision WHA69(14).

3. PROMOTING HEALTH THROUGH THE LIFE COURSE: Item 13 of the agenda (continued)

Health in the 2030 Agenda for Sustainable Development: Item 13.2 of the agenda (document A69/15) (continued from the third meeting)

The CHAIRMAN explained that, following informal consultations conducted under the chairmanship of the representative of the United States of America, the text of a draft resolution had been agreed upon, which read:

The Sixty-ninth World Health Assembly,

(PP1) Reaffirming WHO's Constitution, which states that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition;

(PP2) Reaffirming also United Nations General Assembly resolution 70/1 Transforming our World: the 2030 Agenda for Sustainable Development (2015), in which the General Assembly adopted the outcome document of the United Nations summit for the adoption of the post-2015 development agenda, recognizing that eradicating poverty in all its forms and dimensions, including extreme poverty, is the greatest global challenge and an indispensable requirement for sustainable development and envisaging a world free of poverty, hunger, disease and want, a world of universal respect for human rights and human dignity that includes equitable and universal access to health care and social protection, and where physical, mental and social well-being are assured;

(PP3) Reaffirming UNGA resolution 69/313 of 27 July 2015 on the Addis Ababa Action Agenda of the Third International Conference on Financing for Development, which is an integral part of the 2030 Agenda for Sustainable Development, supports and complements it, helps to contextualize its means of implementation targets with concrete policies and actions, and reaffirms the strong political commitment to address the challenge of financing and creating an enabling environment at all levels for sustainable development in the spirit of global partnership and solidarity;

(PP4) Recognizing the achievements of the Millennium Development Goals in galvanizing collective action at global level for better health outcomes, in particular in meeting global targets for HIV, tuberculosis, and malaria and in reducing child mortality by 53% and maternal mortality by 44%, reductions which are cause for celebration, despite being short of the targets of the Goals;

(PP5) Recalling resolutions WHA66.11 (2013) and WHA67.14 (2014) on health in the post-2015 development agenda which point to the importance of health in meeting broader sustainable development goals and the need for accelerated progress toward the unfinished business of the Millennium Development Goals;

(PP6) Recognizing the importance of the numerous WHO strategies and action plans relating to health, health systems, and public health as useful tools in taking forward the work on the 2030 Agenda for Sustainable Development, and stressing that the Organization's support to countries in implementing these strategies should be provided in a coherent way, aligned to national needs, contexts and priorities, and in efficient coordination with other UN agencies;

(PP7) Recognizing also the opportunity provided by the 2030 Agenda for Sustainable Development for adopting a more integrated and multisectoral approach to health, health promotion and well-being that acknowledges health systems as a coherent entity of functions and services rather than a series of discrete disease or subject-specific initiatives;

(PP8) Recognizing further 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 and vaccines, 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;¹

(PP9) Recognizing that health workers and the public health workforce are integral to building strong and resilient health systems that contribute to the achievement of the Sustainable Development Goals;

(PP10) Recalling resolution EBSS3.R1 (2015) on Ebola, in which the Executive Board recognized the urgency for all countries of having strong, resilient and integrated health systems capable of fully implementing the International Health Regulations (2005), and of having the capacity for health-related emergency preparedness and progress towards universal health coverage that promotes universal, equitable access to health services and ensures affordable, good-quality service delivery;

(PP11) Recognizing the importance of strengthening health systems and building capacities for broad public health measures, health protection and promotion and work to tackle social, economic, and environmental determinants of health, in support of ensuring healthy lives and promoting well-being for all at all ages;

(PP12) Recalling further the importance of fostering alignment and coordination of global health interventions in the area of health systems strengthening, including at the primary health care level, and recognizing the important role WHO should play in this regard;

(PP13) Taking note of the significant infrastructure, assets and human resources of the global polio eradication initiative, and the ongoing legacy process across countries as appropriate;

(PP14) Emphasizing the need for community engagement to focus attention on more rational and forward looking integration of health workers at community level into functional health systems aligned with country objectives and actions, and recognizing them as key players to extend and deliver basic health services directly to communities to achieve the goals of the 2030 Agenda for Sustainable Development;

Goals

(PP15) Reaffirming that the goals and targets of the 2030 Agenda for Sustainable Development are integrated and indivisible, balance the three dimensions of sustainable development: the economic, social, and environmental, seek to achieve gender equality and the empowerment of women and girls, are global in nature and universally applicable, taking into account different national realities, capacities and levels of development and respecting national policy space and priorities;

(PP16) Welcoming the 2030 Agenda for Sustainable Development, including inter alia Sustainable Development Goal 3 “Ensure healthy lives and promote well-being for all at all ages”, and reaffirming its specific and interlinked targets as well as other health related goals and targets and emphasizing the importance of health systems strengthening as it is critical to the achievement of all targets;

(PP17) Reaffirming also the specific commitments to promote physical and mental health and well-being, and to extend life expectancy for all, contained in the 2030 Agenda for Sustainable Development including: achievement of universal health coverage and access to quality health care; ensuring that no one is left behind; acceleration of the progress made to date in reducing newborn, child and maternal mortality by ending all such preventable deaths before 2030; universal access to sexual and reproductive health-care services, including for family planning, information and education; ending the epidemics of HIV/AIDS, TB and Malaria as well as acceleration of the fight against hepatitis, Ebola and other communicable diseases and epidemics, including by addressing growing antimicrobial resistance and the problem of

¹ Reference to the UHC resolution (WHA67.14).

neglected tropical diseases affecting developing countries; and prevention and treatment of noncommunicable diseases, including behavioural, developmental and neurological disorders, which constitute a major challenge for sustainable development;

(PP18) Asserting that health is not just an end in itself, but is a means for reaching other targets of the goals and targets of the 2030 Agenda for Sustainable Development, and noting that investments in health contribute to sustainable inclusive economic growth, social development, environmental protection, and the eradication of poverty and hunger and to reduce inequality, and also acknowledging the reciprocal benefits between the attainment of the health goal and the achievement of all other goals;

(PP19) Reaffirming the Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property;¹

Means of implementation

(PP20) Recognizing also that this agenda, including the Sustainable Development Goals, can be met within the framework of a revitalized global partnership for sustainable development, supported by the concrete policies and actions outlined in the Addis Ababa Action Agenda, which is an integral part of the 2030 Agenda for Sustainable Development, and which supports, complements and helps contextualize the 2030 agenda's means of implementation targets, including its Technology Facilitation Mechanism, and which relates to domestic public resources, domestic and international private business and finance, international development cooperation, international trade as an engine for development, debt and debt sustainability, addressing systemic issues and science, technology, innovation and capacity-building, and data, monitoring and follow-up;

(PP21) Reiterating that the means of implementation and targets under Goal 17 and under each Sustainable Development Goal are key to realizing the Agenda and are of equal importance with the other Goals and targets and also reaffirming targets 3a, 3b, 3c, and 3d, as well as other interlinked targets essential to achieve the 2030 Agenda for Sustainable Development;

(PP22) Reaffirming that the scale and ambition of the 2030 Agenda for Sustainable Development requires a revitalized Global Partnership for Sustainable Development to mobilize the necessary means to ensure its implementation, noting that this Partnership will work in a spirit of global solidarity, in particular solidarity with the poorest and with people in vulnerable situations, and that it will facilitate an intensive global engagement in support of implementation of all the Goals and targets, bringing together Governments, the private sector, civil society, the United Nations system and other actors and mobilizing all available financial and non-financial resources;

Follow up and review

(PP23) Recalling paragraph 48 of UNGA Resolution 70/1 of 25 September 2015, entitled "Transforming our world: the 2030 Agenda for Sustainable Development," to assist governments in their follow-up and review on the Goals and targets, including the means of implementation, and affirming the health sector's commitment to contribute to and support that process, in particular the commitment to strengthen statistical capacities in developing countries;

(PP24) Recognizing that the High Level Political Forum under the auspices of the General Assembly and the Economic and Social Council will have the central role in overseeing, follow-up and review at the global level,

¹ Insert reference to the action plan.

(OP) 1. URGES Member States:¹

- (1) to scale up comprehensive action at the national, regional and global levels, to achieve the goals and targets of the 2030 Agenda for Sustainable Development relating to health by 2030;
- (2) to prioritize health system strengthening, including ensuring an adequately skilled and compensated health workforce, in order to achieve and sustain universal health coverage, defined as universal access to quality promotion, prevention, treatment, rehabilitation and palliation services, including access to safe, effective, quality and affordable essential medicines and vaccines for all, ensuring financial risk protection for all with a special emphasis on the poor, vulnerable, and marginalized segments of the population² as fundamental to the achievement of the 2030 Agenda for Sustainable Development;
- (3) to emphasize the need for cooperative action at the national, regional, and global level across and within all government sectors to tackle social, environmental and economic determinants of health, to reduce health inequities, in particular through the empowerment of women and girls, and contribute to sustainable development, including “health in all policies” as appropriate;
- (4) to appropriately prioritize investments in health and strengthen the mobilization and effective use of domestic and international resources for health in accordance with the broad multisectoral impact that health investments can have on economies and communities;
- (5) to support the research and development of vaccines and medicines for the communicable and noncommunicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use the full provisions in the Agreement on Trade Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health, and, in particular, provide access to medicines for all;³
- (6) to strengthen the dialogue between medical, veterinary, and environmental communities with a special attention to emerging and re-emerging diseases, along with the emergence of antimicrobial resistant pathogens in a way that fosters strengthened and improved surveillance, research, preventive measures and training to ensure or to build capacities to address and manage these threats;
- (7) to develop, on the basis of existing mechanisms wherever possible, quality, inclusive, transparent national accountability processes, consistent with national policies, plans and priorities, for regular monitoring and review of progress towards the goals and targets of the 2030 Agenda for Sustainable Development, which should form the basis for global and regional progress assessment;

(OP) 2. REQUESTS the Director-General:

- (1) to promote a multisectoral approach and the active engagement of WHO at all levels to coordinated implementation of the goals of the 2030 Agenda for Sustainable Development with regard to health, pursuant to the principle that the goals of the 2030 Agenda for Sustainable Development are integrated and indivisible, including through alignment and improved collaboration across WHO programmes;

¹ And, where applicable, regional economic integration organizations.

² Reference to the UHC resolution (WHA67.14).

³ 3b from SDGs.

- (2) to engage, in the context of UN system wide strategic planning, implementation and reporting, in order to ensure coherent and integrated support to implementation of the Agenda 2030 for Sustainable Development;
- (3) to take a proactive role in supporting integrated implementation of the 2030 Agenda for Sustainable Development at national, regional and global level and, in consultation with Member States, develop a long-term plan for maximizing the impact of the contributions of WHO at all levels toward the achievement of the 2030 Agenda for Sustainable Development;
- (4) to take steps to ensure that needed capacities and resources, at all levels of the Organization, are developed and maintained for the successful achievement of the 2030 Agenda for Sustainable Development, particularly to support comprehensive and integrated national plans for health as part of implementation of the 2030 Agenda for Sustainable Development, recognizing that needed competencies include the ability to work with multiple sectors, responding to a broader set of health priorities including supporting progress towards universal health coverage, and providing capacity building or technical support;
- (5) to support Member States in strengthening research and development of new technologies and tools, as well as health technology assessment, paying special attention to the health research and development needs of developing countries, building on relevant strategies, action plans and programmes, in particular on the basis of the Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property and its follow up processes for achievement of the 2030 Agenda for Sustainable Development, in particular for achieving access for all to quality, safe, effective, and affordable vaccines and medicines and diagnostics for communicable and noncommunicable diseases;
- (6) to support Member States to undertake health systems research to develop more effective approaches to ensuring and delivering universal access to health services, paying special attention to the needs of developing countries;
- (7) To facilitate enhanced North–South, South–South and triangular regional and international cooperation on and access to health-related science, technology and innovation and enhance knowledge sharing on mutually agreed terms, including through improved coordination among existing mechanisms, in particular at the United Nations level, and through a global technology facilitation mechanism;
- (8) to work with Member States to ensure that WHO shall effectively contribute to the follow-up to the 2030 Agenda for Sustainable Development, within its existing mandate, by supporting the thematic reviews of progress on the Sustainable Development Goals, including cross-cutting issues, where possible, feeding into and being aligned with the cycle of the High-Level Political Forum, according to the modalities to be established by the General Assembly and ECOSOC in the context of the High-Level Political Forum;
- (9) to report to Member States on a regular basis, at least every two years, on global and regional progress towards achieving the health goal as a whole and its interlinked targets, as well as other health related goals and targets of the 2030 Agenda for Sustainable Development, including a focus on universal health coverage and equity;
- (10) to support Member States in strengthening national statistical capacity at all levels, in particular in developing countries, in order to ensure high quality, accessible, timely, reliable, and disaggregated health data including through, where appropriate, the Health Data Collaborative;
- (11) to support Member States to strengthen reporting on the 2030 Agenda on Sustainable Development in particular the health goal and its interlinked targets;
- (12) to take the 2030 Agenda for Sustainable Development into consideration in the development of the Programme Budget and the General Programme of Work, as appropriate;

(13) to report on progress in implementing this resolution on a regular basis, at least once every two years, to the Seventieth World Health Assembly through the Executive Board.

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

Resolution: Health in the 2030 Agenda for Sustainable Development			
A. Link to the general programme of work and the programme budget			
1. Please indicate to which impact and outcome in the Twelfth General Programme of Work, 2014–2019 and which output in the Programme budget 2016–2017 this draft resolution will contribute if adopted. The resolution cuts across all areas of WHO work and thus all outcomes of the Twelfth General Programme of Work and outputs of the Programme budget 2016–2017.			
2. If there is no link to the results as indicated in the Twelfth General Programme of Work, 2014–2019 and the Programme budget 2016–2017, please provide a justification for giving consideration to the draft resolution. Not applicable.			
3. What is the proposed timeline for implementation of this resolution? The 15 years from 2016 to 2030, in line with the Sustainable Development Goals. <i>If the timeline stretches to future programme budgets, please ensure that further information is provided in the costing section.</i>			
B. Budgetary implications of implementation of the resolution The budgetary implications of this general resolution, should any arise, would appear only after the implications of the resolution for WHO's work have crystallized.			
1. Current biennium: estimated budgetary requirements, in US\$ million			
Level	Staff	Activities	Total
Country offices	Not applicable.	Not applicable.	Not applicable.
Regional offices	Not applicable.	Not applicable.	Not applicable.
Headquarters	Not applicable.	Not applicable.	Not applicable.
Total	Not applicable.	Not applicable.	Not applicable.
1(a) Is the estimated budget requirement in respect of implementation of the resolution fully included within the current programme budget? (Yes/No) Not applicable.			

1(b) Financing implications for the budget in the current biennium: <ul style="list-style-type: none"> – How much is financed in the current biennium? Not applicable. – What are the gaps? Not applicable. – What action is proposed to close these gaps? Not applicable. 			
2. Next biennium: estimated budgetary requirements, in US\$ million			
Level	Staff	Activities	Total
Country offices	Not applicable.	Not applicable.	Not applicable.
Regional offices	Not applicable.	Not applicable.	Not applicable.
Headquarters	Not applicable.	Not applicable.	Not applicable.
Total	Not applicable.	Not applicable.	Not applicable.
2(a) Financing implications for the budget in the next biennium: <ul style="list-style-type: none"> – How much is currently financed in the next biennium? Not applicable. – What are the financing gaps? Not applicable. – What action is proposed to close these gaps? Not applicable. 			

The representative of the UNITED STATES OF AMERICA said that the informal consultations had resulted in a strong draft resolution which, he hoped, would put the Organization on the right path to achieve the goals of the 2030 Agenda for Sustainable Development. Amendments had subsequently been suggested in paragraph 1(6), to replace the final word “threats” with “global health challenges”; and in paragraph 2, to add a paragraph 2(3)bis that would read: “to work with the Inter-agency Expert Group on SDG Indicators, as appropriate, for the further development and finalization of the health-related Sustainable Development Goal indicators”.

The representative of the NETHERLANDS, speaking on behalf of the European Union and its Member States, welcomed the draft resolution. However, he would have liked to see stronger wording on gender equality and the empowerment of women and girls. The mainstreaming of gender equality made investment in the Sustainable Development Goals more effective and efficient, benefiting individuals, families and societies. Gender equality was particularly relevant in the area of health and he had therefore been surprised by the concerns raised by some delegations.

The representative of MALAYSIA said that explicit action was needed to influence governance in policy areas other than health in order to promote and protect health. She supported the draft resolution.

The representative of the INTERNATIONAL COUNCIL OF NURSES, speaking at the invitation of the CHAIRMAN, said that nurses were critical to achieving the Sustainable Development Goals. Health care workers were the solution to many of the challenges of equitable geographical distribution and regional inequality which needed to be solved to achieve universal health coverage. He welcomed the inclusion of noncommunicable diseases and their risk factors in the Sustainable

Development Goal metrics, with clear targets and indicators. In view of nurses' central role and in order to mobilize their expertise to the full, he encouraged WHO and Member States to involve nurses actively in the planning and development of relevant policies and strategies.

Having asked the Secretariat to read out the amendments to the draft resolution, the CHAIRMAN said he 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 14 of the agenda (resumed)

Promoting the health of migrants: Item 14.7 of the agenda (document A69/27) (continued from the twelfth meeting, section 3)

The representative of MALTA observed that, over the past decade, his country had been at the forefront of the migration crisis, receiving an influx of thousands of migrants and asylum seekers. Such movements placed a strain on the sustainability of health systems for small island countries like his own, where reserve resource capacities were limited. Following an assessment conducted by WHO, migrant influxes were being incorporated into Malta's national emergency preparedness plans. He welcomed the policy advice and technical assistance provided by WHO and looked forward to continued collaboration with the Organization in the future.

The representative of CANADA said that the arrival of 25 000 Syrian refugees in Canada since December 2015 had raised awareness among national stakeholders of the need to better understand the long-term health system needs of refugees to improve public health strategies and allocate resources more efficiently. She welcomed opportunities to share effective approaches and best practices with other host countries to improve the delivery of health services to migrants and refugees and recognized the work of WHO in addressing the health needs of such vulnerable populations worldwide.

The representative of BRAZIL congratulated the Secretariat on its work with the International Organization for Migration and UNHCR to improve health care for displaced populations worldwide. In Brazil, all migrants and refugees had access to public health care in cases of emergency, and could access other health services once they had obtained a legal status. She reaffirmed Brazil's commitment to international collaboration and supported the Secretariat's actions to expand and improve assistance to migrants and refugees in host countries.

The representative of COLOMBIA said that it was essential to recognize the positive contribution of migrants to society and to prevent all forms of stigmatization and discrimination. The challenges generated by international migration called for a focus on cooperation, dialogue, the exchange of knowledge and respect for human rights. Experience had shown that unilateral measures were inadequate, increasing the vulnerability and marginalization of migrants. Colombia had been promoting cooperation partnerships with neighbouring countries, and strengthening capacities by designing and implementing policies that promoted access to health for migrants. He hoped that future reports by the Secretariat would focus not only on the challenges posed by migrants but also on the contributions of migrants to national health systems, and he called on WHO to continue its work with other organizations of the United Nations system, notably the International Organization for Migration.

¹ Transmitted to the Health Assembly in the Committee's fifth report and adopted as resolution WHA69.11.

The representative of EGYPT said that some 185 000 refugees and asylum seekers had been registered with UNHCR in Egypt and many more remained unregistered. Health systems and policies had been adapted to deal with the unique and diverse health issues of refugees and migrants, but needed to be strengthened further to ensure better and more equitable access to health for all.

The representative of ECUADOR said that the health of migrants must be included in a comprehensive manner on the international agenda as a global public health policy. Efforts should be made to ensure health promotion and disease prevention, as well as epidemiological surveillance for populations on the move, and particular attention should be given to vulnerable populations. She also called for the implementation of social protection agreements between countries and efforts to ensure a gender and cultural perspective with respect to migrant health. Health care professionals should be trained to ensure that services were provided without any form of discrimination, and ongoing efforts made to improve processes and strategies, including through the use of information and communications technologies.

The representative of THAILAND emphasized the need for cross-regional collaboration in addressing the health of migrants. The future priorities outlined in the document focused primarily on international migrants and refugees; however, the issue of internal migration also required policy attention. A shift in public perception was required to stop migrants from being viewed as a social burden or a source of cheap labour in host countries but as human beings and valuable human capital.

The representative of MALAYSIA said that migrants consistently faced barriers in accessing health systems in their host countries, irrespective of the reason for their migration. While his region was affected by migration, the health sector in source and recipient countries in the region was far from migrant-sensitive. Malaysia welcomed the insistence on policy coherence across various sectors, including the reference to the role of employers and private partners referred to in the future priorities set out in the report.

The representative of NEPAL said that there was a need to design mechanisms that addressed the health needs of migrants without reducing the health services offered to the host population, and took into account the capacity of health care providers and the changing socioeconomic situations of the countries of origin and destination. Given the considerable cross-border movement within single regions, he highlighted the importance of regional strategies to promote the health of migrants.

The representative of TURKEY said that health systems should be redesigned to meet the needs and expectations of migrants. A comprehensive global framework for action on migration and health should be prepared.

The representative of SWEDEN said that migrants' health should be approached from a human rights perspective, and that consideration should be given to the gender dimension and to the particular efforts required to protect large numbers of unaccompanied minors. Moreover, it should be considered as a long-term issue, since many migrants would stay for extended periods in their host communities. Sweden had actively participated in work at the European regional level to draft the strategy and action plan on refugee and migrant health for the WHO European Region 2016–2022, which would be submitted to the WHO Regional Committee for Europe for adoption at its forthcoming 66th session.

The observer of CHINESE TAIPEI said that given the large immigrant population in Chinese Taipei, measures had been taken to enhance health care services for migrants, such as including migrants in epidemiological surveillance and vaccine programmes without discrimination. Foreign workers and students were entitled to universal health insurance, and outreach home visits were conducted to offer additional education and care.

The observer of the INTERNATIONAL FEDERATION OF RED CROSS AND RED CRESCENT SOCIETIES said that all governments should take measures to protect the dignity and safety of all migrants. Migrants were particularly vulnerable to abuse, violence, exploitation and discrimination, and their health could be compromised further owing to barriers in accessing health and social services, and a lack of continuity of care for chronic conditions. While national governments and international agencies had a key role to play in addressing health issues related to migration, civil society involvement was also crucial. The Red Cross and Red Crescent Movement was committed to addressing the needs and vulnerability of migrants to provide protection and humanitarian assistance, and to enhance the continuum of care for all those on the move.

The representative of the INTERNATIONAL COUNCIL OF NURSES, speaking at the invitation of the CHAIRMAN, said that nurses were on the front line of health service provision to migrants and refugees. The International Council of Nurses supported the implementation of health policies to increase equitable access to health services and build capacity in the health workforce to better understand and address issues unique to migrants and refugees. WHO and national governments should work cooperatively with nurses in the planning, implementation and evaluation of health strategies for migrants and refugees.

The representative of the INTERNATIONAL FEDERATION OF MEDICAL STUDENTS' ASSOCIATIONS, speaking at the invitation of the CHAIRMAN, underscored the urgent need to take action to protect the health of migrants, in particular through capacity building among the health workforce. Data collection on migrant populations disaggregated by sex, age and socioeconomic and legal status was essential. Steps should be taken to identify problems with regard to access and appropriateness of health services for migrants, and to provide migrants with health-related information in an easily understandable format. Migrants and refugees should be included in decision making concerning health services delivery. As migration continued, its implications for public health would increase. Migrants' access to health care should therefore be improved as a matter of urgency.

The representative of the INTERNATIONAL PHARMACEUTICAL FEDERATION, speaking at the invitation of the CHAIRMAN, said that pharmacists provided an important entry point into the health system for migrants. Given the considerable barriers to communication, the International Pharmaceutical Federation had developed a range of tools, in picture format and in a variety of languages, to provide information for migrants on health care issues. Many migrants were health care professionals and the Federation was helping Syrian migrant pharmacists integrate into the health care provision system in their host countries.

The representative of the WORLD MEDICAL ASSOCIATION, INC., speaking at the invitation of the CHAIRMAN, said that governments should ensure access to adequate health care and living conditions for all individuals regardless of their civil or political status, and increase training on migrant health needs, including mental health, for the health workforce. Governments should also encourage universities to include migrant health on their curricula, raise awareness among future health workers, and speak out against discriminatory legislation and practices.

The representative of MEDICUS MUNDI INTERNATIONAL – INTERNATIONAL ORGANISATION FOR COOPERATION IN HEALTH CARE, speaking at the invitation of the CHAIRMAN, said that Member States must adhere to international human rights law in their approach to migrant health, and respect the right to health of migrants by ensuring access to quality health facilities, health services and medicines. WHO should demonstrate strong leadership in supporting interagency and interregional coordination and action to combat cruel and discriminatory practices against migrants, and include in its future priorities on migrant health sustainable action on the social, political and economic determinants of migration. WHO should also develop strategies that took into account global inequality and climate change as drivers of migration.

The representative of INTERNATIONAL PLANNED PARENTHOOD FEDERATION, speaking at the invitation of the CHAIRMAN, said that all individuals, especially the most vulnerable, should have access to sexual and reproductive health services in humanitarian emergencies, which were often overlooked in times of crisis. WHO and Member States should provide support in order to prioritize minimum initial service package interventions and ensure that all countries and regions were prepared to respond to crises.

The representative of the INTERNATIONAL ORGANIZATION FOR MIGRATION said that the issue of migrant health applied not only to individuals affected by forced displacement but also to those in irregular situations. Universal health coverage could be achieved only if health systems addressed the needs of all persons without discrimination. She hoped that the second global consultation on migrant health to be held jointly by WHO and the International Organization for Migration in October 2016 would promote a greater understanding of migrant health, create and strengthen a multisectoral and interregional platform, and reinforce health systems to improve health care for migrants. Migration was not a problem to be solved but a human reality to be managed.

The ASSISTANT DIRECTOR-GENERAL (Health Systems and Innovation) recalled that the 2030 Agenda called for the full respect of the human rights of migrants and noted that achievement of the Sustainable Development Goals would address multiple economic, social and environmental determinants of migration. She acknowledged that migration was indeed a global problem and apologized that the report did not mention that the Region of the Americas was also affected. Regarding voluntary reporting, the Secretariat was planning to develop appropriate indicators and mechanisms for periodic reporting on progress on migrant health. In response to the request for greater technical assistance on emergency risk management and other migrant health issues, the Secretariat would consider how best to organize such activities between headquarters, regional and country offices. She noted the request for consideration of information on human trafficking and the loss of human life in transit in the recent refugee crisis. WHO was addressing migrant health through the promotion of health system strengthening in order to prevent crises, and was working very closely on the issue with the International Organization for Migration.

The EXECUTIVE DIRECTOR ad interim (Outbreaks and Health Emergencies) noted the request for future reports not only to describe current contexts and the action taken by the Secretariat, but also to reflect the best practices of Member States in adapting national policies and capacities to meet the needs of migrants and refugees.

The Committee noted the report.

5. NONCOMMUNICABLE DISEASES: Item 12 of the agenda (continued)

Public health dimension of the world drug problem including in the context of the special session of the United Nations General Assembly on the world drug problem, held in April 2016: Item 12.6 of the agenda (document A69/12)

The CHAIRMAN drew attention to a draft decision proposed by the delegations of Argentina, Australia, Colombia, Guatemala, Mexico, the Netherlands, Norway, Panama, South Africa, Sweden, Switzerland, the United States of America, Uruguay and Zambia, which read:

The Sixty-ninth World Health Assembly,

PP1 *Having* considered the report on the public health dimension of the world drug problem¹ and the outcome of the thirtieth special session of the United Nations General Assembly on the world drug problem held in New York from 19 to 21 April 2016, as well as the 2030 Agenda for Sustainable Development;

PP2 *Recognizing* that the enjoyment of the highest attainable standard of health is a fundamental right of every human being as stated in the WHO Constitution and that WHO is the directing and coordinating authority for health within the United Nations system;

PP3 *Recalling* that the primary concern of the international drug control conventions is to protect the health and welfare of humankind and that WHO is one of their four treaty bodies;

PP4 *Welcoming* United Nations General Assembly resolution RES/S-30/1 (2016) that adopted the outcome document entitled “Our joint commitment to effectively addressing and countering the world drug problem”, which provides a renewed commitment to a comprehensive, integrated and balanced approach to tackling the world drug problem, aiming to promote and protect the health, safety and well-being of all humanity;

PP5 *Recognizing* the need to strengthen health and welfare measures, as well as to enhance multisectoral cooperation at all levels, including cooperation with, and among, the UNODC, the International Narcotics Control Board, WHO and other relevant United Nations entities, to ensure effective implementation of the operational recommendations of resolution RES/S-30/1, in particular those related to health,

(OP.1) Decided to request the Director-General:

(OP1.1) to develop, within the existing mandate of WHO, a comprehensive strategy and action plan to strengthen action on the public health dimension of the world drug problem, including consultation with Member States, as well as other competent United Nations organizations, to be submitted to the Seventy-first World Health Assembly through the Executive Board at its 142nd session;

(OP1.2) to submit a progress report on the development of the comprehensive strategy and action plan on the public health dimension of the world drug problem to the Seventieth World Health Assembly.

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

Decision: Public health dimension of the world drug problem including in the context of the special session of the United Nations General Assembly on the world drug problem, held in April 2016	
A. Link to the general programme of work and the programme budget	
1.	<p>Please indicate to which impact and outcome in the Twelfth General Programme of Work, 2014–2019 and which output in the Programme budget 2016–2017 this draft decision will contribute if adopted.</p> <p>General Programme of work – Category 2 outcome: Increased access to services for mental health and substance use disorders.</p> <p>Programme budget – Output 2.2.3 Expansion and strengthening of country strategies, systems and interventions for disorders caused by alcohol and other psychoactive substance use enabled.</p>

¹ Document A69/12.

2. If there is no link to the results as indicated in the Twelfth General Programme of Work, 2014–2019 and the Programme budget 2016–2017, please provide a justification for giving consideration to the draft decision.

Not applicable.

3. What is the proposed timeline for implementation of this decision?

The proposed timeline for implementation is 8 months (from June 2016 to January 2017).

If the timeline stretches to future programme budgets, please ensure that further information is provided in the costing section.

B. Budgetary implications of implementation of the decision

1. Current biennium: estimated budgetary requirements, in US\$ million

Level	Staff	Activities	Total
Country offices	–	–	–
Regional offices	–	–	–
Headquarters	0.3	0.05	0.35
Total	0.3	0.05	0.35

- 1(a) Is the estimated budget requirement in respect of implementation of the decision fully included within the current programme budget? (Yes/No)

No.

1(b) Financing implications for the budget in the current biennium:

- How much is financed in the current biennium?

US\$ nil

- What are the gaps?

US\$ 0.35 million

- What action is proposed to close these gaps?

The gaps will be tackled through coordinated resource mobilization efforts.

2. Next biennium: estimated budgetary requirements, in US\$ million

Level	Staff	Activities	Total
Country offices	–	–	–
Regional offices	–	–	–
Headquarters	–	–	–
Total	–	–	–

2(a) Financing implications for the budget in the next biennium:

- How much is currently financed in the next biennium?

Not applicable.

- What are the financing gaps?

US\$ nil

- What action is proposed to close these gaps?

Not applicable.

The representative of the NETHERLANDS, speaking on behalf of the European Union and its Member States, underscored the importance of public and individual health protection at both the national and international levels. Drug users should be considered first and foremost as persons in need of attention, counselling, care and treatment in order to improve their health, enhance their social reintegration, and prevent them from being marginalized or stigmatized. It was regrettable that it had not been possible to reach agreement on the draft decision. WHO played a crucial role in supporting Member States and institutions of the international drug control system. It should continue its efforts in cooperation with UNODC and the International Narcotics Control Board to elaborate a balanced, integrated and evidence-based approach to all health aspects of the drug problem, and fully play its role in the implementation of the recommendations contained in the outcome document of the special session of the United Nations General Assembly.

The representative of URUGUAY said that experience had shown that punitive approaches alone were not effective in addressing drug use. National and international policies should focus on the human aspect of the world drug problem in order to attain objectives related to health and well-being. The Secretariat should develop guidance to assist Member States in meeting the commitments undertaken at the special session, and continue to collaborate with other specialized organizations on the issue. It was essential to guarantee access to and the availability of quality health services and treatment and rehabilitation services for drug users, through evidence-based strategies and an approach focused on human rights. It was also necessary to provide for the medical use of controlled medicines and promote the development of research. She expressed regret at the failure to reach consensus on the draft decision.

The representative of SWITZERLAND expressed satisfaction that the special session had served to highlight the importance of the public health aspect of the drug problem. While the failure to reach consensus on the draft decision was disappointing, all United Nations bodies should work together in an inclusive and coherent manner to implement the recommendations in the outcome document, with a view to attaining of the objectives of the 2030 Agenda and the goals of WHO's strategies on communicable diseases. WHO's continued involvement was vital in ensuring that health remained an important aspect of the world drug problem.

The representative of MEXICO said that it was imperative to place individuals at the centre of the discussions and policies on the world drug problem. Drug use should be addressed primarily as a public health problem, as it was a threat to the full development of individuals. It was regrettable that consensus had not been achieved on the draft decision. He requested the Director-General to take the necessary measures within the framework of WHO's mandate to support Member States in implementing the health-related operational recommendations of the special session, and to update the Commission on Narcotic Drugs on the progress achieved. The item should be included on the agenda of the 140th session of the Executive Board and a progress report submitted to the Seventieth World Health Assembly.

The representative of the CZECH REPUBLIC highlighted the importance of monitoring and evaluation for the development of evidence-based drug policies, and of ensuring the availability of psychotropic drugs for medical use. WHO must lead the work of UNODC and other international organizations in that area, to strengthen the monitoring and evaluation capacities of Member States. It was unacceptable that the majority of the global population had no access to controlled medicines; WHO should urgently consider rescheduling cannabis and products derived from it.

The representative of COLOMBIA called for comprehensive, balanced and human rights-based policies in the area of drug control. Greater coherence, cooperation and information sharing were required within the United Nations system, and the role of WHO in countering the world drug problem should be strengthened. The Secretariat should provide the technical support that Member States

required to continue to develop public policies to tackle the world drug problem. Since it had not been possible to reach consensus on the decision, the item should be included on the agenda of the 140th session of the Executive Board.

The representative of the UNITED KINGDOM OF GREAT BRITAIN AND NORTHERN IRELAND strongly encouraged WHO to continue its important work in addressing the public health dimension of the public health problem and praised the excellent work of the WHO Expert Committee on Drug Dependence. Noting with regret the failure to reach consensus on the decision, he looked forward to further discussion of the item at future meetings of the governing bodies.

The representative of ESTONIA said that stronger action should be taken to address the increasing drug problem, including a greater focus on the sale of illegal drugs online and on combating the rise in new psychoactive substances. Outlining some of the measures taken by his Government, he said that preventive action should be enhanced with a stronger emphasis on children, families and schools, and counselling, care, treatment and social reintegration. He would welcome discussion of the item at the next meeting of the governing bodies, and called on WHO to play its role in implementing the recommendations made at the special session.

The representative of PERU said that the special session outcome document had been wrongly interpreted in paragraph 5 of the report, since the outcome document stated that policies were already based on a balanced and comprehensive approach and were valid in their existing form. Paragraph 16 of the report focused entirely on harm reduction, an issue on which no consensus had been reached at the special session. The Commission on Narcotic Drugs or the International Narcotics Control Board, rather than WHO, should be responsible for following up on the agreements reached at the special session. Several vital elements contained in the outcome document were omitted in the report, such as the references to the role of the Commission on Narcotic Drugs as the policy-making body of the United Nations with prime responsibility for drug control matters, and that of UNODC as the leading entity in the United Nations system for addressing and countering the world drug problem. Health, although important, was only one aspect of the world drug problem.

The representative of NORWAY said that WHO should continue to demonstrate global leadership on the public health dimension of the world drug problem, within its existing mandate. It should provide technical support to Member States, and remain actively involved in the work on the wider health dimensions of the world drug problem in preparation for the 2019 review of the Political Declaration and Plan of Action on International Cooperation towards an Integrated and Balanced Strategy to Counter the World Drug Problem. He commended the efforts of the representatives of Colombia to reach an agreement on the draft decision and would welcome inclusion of the item on the agenda of the 140th session of the Executive Board.

The representative of CUBA said that she would not welcome the use of any terminology or any actions that might damage the current drug control system. She supported the existing international legal framework. WHO's advisory role should be based on the relevant global political and normative framework.

The representative of ECUADOR said that she agreed with the statements made by the representatives of Mexico and Uruguay and she shared the concerns expressed by the representative of Cuba.

The representative of JAPAN said that an integrated, multidisciplinary, mutually-reinforcing, balanced and evidence-based approach must be taken to counter the world drug problem, which was a growing concern. He praised WHO's important contribution to the public health aspects of the

problem, and called on it to continue its efforts, including through further cooperation with the Commission on Narcotic Drugs, other United Nations entities and Member States.

The representative of AUSTRIA welcomed the outcome document of the special session and highlighted the need for cross-sectoral effort to achieve an effective drug policy. UNODC should assume the lead in coordinating international drug control policy and he wholeheartedly supported the establishment of a UNODC office in Geneva. Strengthened coordination between all stakeholders would be crucial in addressing the public health dimension of the issue and achieving the policy targets contained in the Political Declaration and Plan of Action on International Cooperation towards an Integrated and Balanced Strategy to Counter the World Drug Problem. He supported the proposal made by the representative of Colombia to refer the matter to the 140th session of the Executive Board for further discussion.

The representative of SENEGAL said that action aimed at reducing drug use should focus on prevention, treatment and rehabilitation, and recalled that his country had established a support centre for drug users. Particular attention should be given to tackling the socioeconomic determinants of drug abuse and to supporting vulnerable, at-risk individuals and communities.

The representative of NICARAGUA said that Member States should develop national strategies to combat drug use that took into account the cultural specificities and historical context of their respective countries. He looked forward to further discussion of the world drug problem in a variety of forums and noted WHO's important role with respect to the public health dimension.

The representative of the UNITED STATES OF AMERICA welcomed the outcome document and its recognition of the need to increase the focus on the health dimensions of the world drug problem. Although WHO already cooperated closely with UNODC and should implement the health aspects of the outcome document within its existing mandate, there was a need for greater system-wide coherence; the Commission on Narcotic Drugs should provide a road map for the implementation of the operational recommendations. He expressed regret at the lack of consensus on the draft decision on the issue and would welcome further consideration of the item by the Executive Board at its 140th session.

The representative of GUATEMALA said that the failure to agree on the draft decision was regrettable. However, he was confident that WHO would implement the relevant operational recommendations set out in the outcome document of the special session. WHO should continue to cooperate with other United Nations organizations with due regard to their respective technical capacities and mandates, and he looked forward to further discussion of the item at the 140th session of the Executive Board.

The representative of AUSTRALIA, while fully supporting the report, expressed regret at the absence of consensus on the draft decision on the agenda item. WHO should continue its efforts to implement the operational recommendations of the outcome document, assist Member States in addressing the health-related aspects and cooperate closely with other relevant United Nations entities. He endorsed the proposal by the representative of Colombia to refer the matter to the 140th session of the Executive Board for consideration.

The representative of ARGENTINA expressed regret at the failure to reach agreement on the draft decision and therefore fully supported the proposal to refer the topic to the 140th session of the Executive Board. His country advocated a comprehensive, balanced, people-centred approach to reduce the supply and demand of illegal drugs, and emphasized the importance of the full respect for human rights and efforts to eliminate the discrimination and stigmatization faced by drug addicts. He called on Member States to tackle the regulatory and legislative obstacles that were resulting in

shortages in controlled substances for scientific and medical purposes, and endorsed the comments made by the representative of Mexico.

The representative of SWEDEN welcomed the outcome document of the special session and urged WHO to pursue its role in tackling the health-related aspects of the world drug problem. Her Government deeply regretted the failure to reach agreement on the matter and therefore supported the inclusion of the topic on the agenda of the 140th session of the Executive Board.

The representative of the RUSSIAN FEDERATION stressed that the approach to the world drug problem should be comprehensive, interdisciplinary and balanced, taking into consideration the issue of reducing supply and demand while providing appropriate treatment and rehabilitation for drug users. WHO should assist Member States in implementing the operational recommendations in the outcome document. The Russian Federation would welcome the establishment of a UNODC office in Geneva, which would help to enhance cooperation between UNODC and WHO.

The representative of CANADA urged the Secretariat to continue to provide technical guidance to Member States on the implementation of the health-related aspects of the outcome document and would support further consideration of the item by the Executive Board at its 140th session.

The representative of ZAMBIA expressed regret that the Committee had not been able to reach a consensus and adopt a draft decision and supported the proposal to include the item on the agenda of the 140th session of the Executive Board. He called for a balanced approach, which did not infringe on the right of access to essential medicines, and urged WHO to work with other relevant organizations of the United Nations system in helping Member States to implement the operational recommendations in the outcome document.

The representative of CHINA said that her country welcomed the introduction of measures aimed at raising awareness, preventing drug use and providing early intervention, treatment and rehabilitation to drug users. Integrated, multisectoral actions to address the public health dimension of the world drug problem should uphold the principles of shared responsibility, national sovereignty and non-interference in internal affairs, with a view to maintaining a stable international drug control system. WHO, for its part, should increase research on drug dependency, especially on new synthetic drugs, taking full account of different cultural backgrounds and countries' respective circumstances, and should organize expert training programmes to train medical professionals in the field of drug use prevention and control. Further efforts should also be made to reach consensus and devise a draft decision on the issue.

The representative of INDONESIA called for a balanced and holistic approach in addressing the world drug problem, recognizing the different challenges facing countries. While her Government welcomed WHO's efforts on the public health dimension, greater coherence with other United Nations system entities should be developed before a decision was taken on an action plan. She looked forward to further discussion of the issue at the 140th session of the Executive Board.

The representative of PORTUGAL welcomed the outcome document and the essential role played by WHO in championing the public health dimension of the world drug problem. He thanked the representatives of Colombia for their efforts to reach consensus on a draft decision and supported the proposal to refer the issue to the 140th session of the Executive Board.

The representative of PANAMA said that the world drug problem was a joint and shared responsibility and had to be tackled in a multilateral fashion. He welcomed the recognition of the health dimension, and highlighted the importance of results with respect to access to essential

medicines and controlled drugs used for pain relief and palliative care. Noting with regret the failure to reach agreement on a decision, he supported the proposals of Mexico and Colombia.

The observer of CHINESE TAIPEI said that Chinese Taipei had launched a number of initiatives to strengthen the regulation of drugs used for medical and scientific purposes and to prevent the abuse or misuse of controlled substances. It had also taken steps to increase the availability of community rehabilitation services for drug addicts. Chinese Taipei looked forward to cooperating and sharing information with global partners.

The observer of the INTERNATIONAL FEDERATION OF RED CROSS AND RED CRESCENT SOCIETIES expressed concern at the humanitarian consequences of approaches relying exclusively on pursuing and punishing drug users, rather than on supporting and treating them. Governments should adopt harm reduction measures that were people-centred, inclusive and focused on human rights.

The representative of the INTERNATIONAL ASSOCIATION FOR HOSPICE AND PALLIATIVE CARE INC., speaking at the invitation of the CHAIRMAN, welcomed the strong public health and people-centred focus of the outcome document. Her association stood ready to assist Member States in implementing the relevant recommendations contained therein.

The representative of the WORLD MEDICAL ASSOCIATION INC., speaking at the invitation of the CHAIRMAN, said that WHO should ensure that palliative care, including access to opioids, was fully integrated in universal health coverage; target interventions towards countries with overly restrictive opioid regulation; uphold medical access to ketamine; conduct information activities aimed at providing a balanced approach on opioid usage; and implement robust mechanisms to monitor global progress towards ensuring access to controlled drugs for pain relief.

The representative of the WORLD HEPATITIS ALLIANCE, speaking at the invitation of the CHAIRMAN, welcomed the efforts to prioritize a public health approach to the world drug problem, particularly given the adverse effect unhelpful drug policies could have on transmission rates of hepatitis and HIV/AIDS, and called for WHO to provide greater input into global drug policy.

The ASSISTANT DIRECTOR-GENERAL (Health Systems and Innovation) thanked speakers for their comments. The Secretariat would work diligently to address the health dimension of the world drug problem within its mandate in close cooperation with UNODC, the International Narcotics Control Board and the Commission on Narcotic Drugs.

The Committee noted the report.

The CHAIRMAN said that, in the absence of consensus on the matter, he took it that the Committee wished to include the item on the agenda of the Executive Board at its 140th session, in January 2017.

It was so decided.¹

¹ Transmitted to the Health Assembly in the Committee's fifth report and adopted as decision WHA69(15).

6. FIFTH REPORT OF COMMITTEE A (document A69/76)

The RAPPORTEUR read out the draft fifth report of Committee A.

The report was adopted.¹

7. CLOSURE OF THE MEETING

After the customary exchange of courtesies, the CHAIRMAN declared the work of Committee A completed.

The meeting rose at 17:25.

¹ See page 382.

COMMITTEE B

FIRST MEETING

Wednesday, 25 May 2016, at 14:40

Chairman: Dr PHUSIT PRAKONGSAI (Thailand)

1. OPENING OF THE COMMITTEE: Item 18 of the agenda

The CHAIRMAN, welcoming participants, extended a special welcome to the representative of the United Kingdom of Great Britain and Northern Ireland, as the Chairman of the Programme, Budget and Administration Committee of the Executive Board, who would report on several agenda items dealt with on behalf of the Executive Board by that Committee at its twenty-fourth meeting (Geneva, 19 and 20 May 2016).

Election of Vice-Chairmen and Rapporteur

The CHAIRMAN informed the Committee that Dr Mahlet Kifle (Ethiopia) and Dr Mohsen Asadi-Lari (Islamic Republic of Iran) had been nominated as Vice-Chairmen and Mr Abdunomon Sidikov (Uzbekistan) as Rapporteur.

Decision: Committee B elected Dr Mahlet Kifle (Ethiopia) and Dr Mohsen Asadi-Lari (Islamic Republic of Iran) as Vice-Chairmen, and Mr Abdunomon Sidikov (Uzbekistan) as Rapporteur.¹

2. ORGANIZATION OF WORK

Following a request made by the representative of INDIA, the CHAIRMAN proposed that consideration of agenda item 16.2 on follow-up to the report of the Consultative Expert Working Group on Research and Development: Financing and Coordination – Report of the open-ended meeting of Member States should be brought forward. He suggested that it should be taken up after consideration of item 19 on health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan. The remaining agenda items allocated to the Committee (contained in document A69/1 Rev.1) would then be dealt with in the order in which they appeared in the programme of work published daily in the *Journal* of the Health Assembly.

It was so agreed.

The representative of the NETHERLANDS, speaking on behalf of the European Union and its Member States, 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. He requested that it should again be invited by the Committee to participate, without vote, in

¹ Decision WHA69(3).

the deliberations of the meetings of subcommittees, drafting groups and other subdivisions dealing with matters falling within the competence of the European Union.

It was so agreed.

3. HEALTH CONDITIONS IN THE OCCUPIED PALESTINIAN TERRITORY, INCLUDING EAST JERUSALEM, AND IN THE OCCUPIED SYRIAN GOLAN: Item 19 of the agenda (documents A69/44, A69/44 Add.1, A69/INF./4, A69/INF./5 and A69/INF./6)

The CHAIRMAN drew attention to a draft decision proposed by the delegation of Kuwait, on behalf of the Arab Group, and Palestine, which read:

The Sixty-ninth World Health Assembly,

PP1 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;

PP2 Taking note of the report of the Director-General on Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan, and noting also the Report of a field assessment of health conditions in the occupied Palestinian territory;

Requests the Director-General:

(OP.1) to report and make practical recommendations on the health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan, to the Seventieth World Health Assembly, through a field assessment conducted by the World Health Organization, with special focus on:

(a) physical and procedural barriers to health access in the occupied Palestinian territory, including as a result of movement restrictions and territorial fragmentation, as well as progress made in the implementation of the recommendations contained in the World Health Organization 2014 report Right to health: Crossing barriers to access health in the occupied Palestinian territory, 2013;

(b) incidents of delay or denial of ambulance service, and the harmful effects of the “back-to-back” procedure for the ambulance transfer of patients across checkpoints;

(c) physical injuries and disabilities, and damage to and destruction of medical infrastructure and facilities, as well as impediments to the reconstruction, development and equipment of these health facilities and to the safety of health care workers;

(d) access to adequate health services on the part of Palestinian prisoners, including the possibility of access to medical staff that can operate independently from the custodial authorities, and the health consequences of the military detention system on prisoners and detainees, especially child detainees, as well as progress made in the implementation of the recommendations contained in the World Health Organization 2012 Right to Health Advocacy Project;

(e) the impact of prolonged occupation and human rights violations on mental, physical and environmental health and on the development of a sustainable health system in the occupied Palestinian territory, including the health consequences of

insecure living conditions notably as a result of displacement, home demolitions and the denial of medical services;

(f) the effect of impeded access to water and sanitation, and food insecurity, on health conditions in the occupied Palestinian territory, particularly in the Gaza Strip, as well as the effect of Israeli actions harming the environment, including the dumping of waste materials which pose a health threat to the civilian populations, and progress made in the implementation of the recommendations contained in the Gaza Strip Joint Health Sector Assessment Report of September 2014;

(g) the provision of financial and technical assistance and support by the international donor community, including through the United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA), and its contribution to improving health conditions in the occupied Palestinian territory;

(OP.2) to provide support to the Palestinian health services, including capacity-building programmes, and the development of strategic plans for investments in specific treatment and diagnostic capacities locally;

(OP.3) to provide health-related technical assistance to the Syrian population in the occupied Syrian Golan;

(OP.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, as well as the health needs of handicapped and injured people;

(OP.5) to propose measures to improve the health of prisoners and ex-prisoners and the re-integration of ex-prisoners into the community, and to provide information to prisoners about how to cope with and report illness;

(OP.6) to provide support to the Palestinian health sector in preparing for emergency situations and scaling up emergency preparedness and response capacities and in reducing shortages in life-saving drugs and medical disposables and equipment;

(OP.7) to support the development of the health system in the occupied Palestinian territory, including development of human resources, with a particular focus on strengthening primary care and integrating mental health provision with primary care services, as well as on health prevention and integrated disease management, and to advise donors on how to best support this activity;

(OP.8) to ensure the allocation of human and financial resources to deliver on these objectives.

The financial and administrative implications for the Secretariat of the adoption of the draft decision were as follows:

Decision: Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan			
A. Link to the general programme of work and the programme budget			
1. Please indicate to which impact and outcome in the Twelfth General Programme of Work, 2014–2019 and which output in the Programme budget 2016–2017 this draft decision will contribute if adopted. Impact goals: 4 and 7 Outcomes: 1.5, 2.1, 2.2, 2.3, 3.1, 3.2, 3.3, 3.4, 4.1, 4.2, 5.1, 5.3, 6.1, 6.4			
2. If there is no link to the results as indicated in the Twelfth General Programme of Work, 2014–2019 and the Programme budget 2016–2017, please provide a justification for giving consideration to the draft decision. Not applicable.			
3. What is the proposed timeline for implementation of this decision? The remainder of the biennium 2016–2017. <i>If the timeline stretches to future programme budgets, please ensure that further information is provided in the costing section.</i>			
B. Budgetary implications of implementation of the decision			
1. Current biennium: estimated budgetary requirements, in US\$ million			
Level	Staff	Activities	Total
Country offices	7.0	9.3	16.4
Regional offices	0.0	0.0	0.0
Headquarters	0.0	0.0	0.0
Total	7.0	9.3	16.4
1(a) Is the estimated budget requirement in respect of implementation of the decision fully included within the current programme budget? (Yes/No) Yes			
1(b) Financing implications for the budget in the current biennium, in US\$ million – How much is financed in the current biennium? US\$ 8.9 – What are the gaps? US\$ 7.5 – What action is proposed to close these gaps? The gaps will be closed through coordinated resource mobilization efforts.			

2. Next biennium: estimated budgetary requirements, in US\$ million			
Level	Staff	Activities	Total
Country offices	–	–	–
Regional offices	–	–	–
Headquarters	–	–	–
Total	Nil	Nil	Nil
2(a) Financing implications for the budget in the next biennium: – How much is currently financed in the next biennium? Not applicable. – What are the financing gaps? Not applicable. – What action is proposed to close these gaps? Not applicable.			

The representative of EGYPT said that the Palestinian health system was under severe pressure as a result of the Israeli occupation and a lack of financial resources adversely affecting the socioeconomic situation of the Palestinian people. The policies adopted by Israel to impede access to health services demonstrated a complete disregard for the right to health. It was unacceptable that people requiring medical treatment had to obtain a permit from Israel before accessing health care. Her Government remained deeply concerned about violence against health-service providers in the West Bank and east Jerusalem, which in some cases had led to the loss of life. Further international support must be provided so that Palestinians could strengthen their health-care system and improve access to medical services.

The representative of PAKISTAN, expressing grave concern at the deteriorating health situation in the occupied Palestinian territory, said that the continued Israeli occupation and brutal use of force had devastated the Palestinian health system, had limited access to food and water, and had caused complex physical and psychological health issues among the affected population, particularly women and children. The recent attacks on health facilities, medical staff and patients represented a stark violation of international law. The Gaza Strip and the West Bank remained largely cut off and were facing health and humanitarian crises owing to the Israeli policy of isolation and violence. The international community must not shy away from its responsibility to uphold the basic right to health. Welcoming WHO's efforts to strengthen the health-care system, she said that waning international technical and financial support must be increased at the earliest possible opportunity in order to address the situation. Her country fully supported the draft decision and wished to be included in the list of sponsors.

The representative of the BOLIVARIAN REPUBLIC OF VENEZUELA said that she supported the draft decision and asked that her country be added to the list of sponsors. WHO's Constitution and the right to health should be respected. Measures should be taken to help to resolve the deterioration in health services in the occupied Palestinian territory and the occupied Syrian Golan, which resulted from policies that restricted the movement of people, limited access to water and food, and caused economic deprivation. Humanitarian aid was urgently needed, and the lack of medicines was becoming critical. Military action in the Gaza Strip had resulted in large numbers of Palestinians being killed, wounded and displaced. The constant threat of violence led to psychological disorders, as well as permanent disabilities, particularly among children. Observers had reported that children and adolescents were being illegally detained and had limited access to health care when in detention. The Syrian authorities alleged that drugs continued to be tested on Syrian and other Arab prisoners.

Restrictions imposed by Israel hindered the import of medical supplies and international donations and the provision of health care.

The representative of CHINA said that the deteriorating health conditions and shortage of essential medicines and health-care personnel described were extremely worrisome. He appreciated WHO's work to stabilize the health system in the occupied Palestinian territory, which should continue. His Government had worked to improve health conditions in the region and encouraged all parties to take effective steps to that end. He emphasized the need for WHO to have access to the occupied Syrian Golan to enable it to evaluate health conditions.

The representative of ISRAEL said that the yearly ritual of naming and shaming Israel diverted attention away from serious discussion of the health challenges facing the world. The Health Assembly should not be used as a forum for biased and discriminatory political discussions. Despite the growing Palestinian terrorist threat, close to 100 000 sick and wounded people from the West Bank had received treatment in Israeli medical facilities. Moreover, the Druze community in the Golan had access to a state-of-the-art medical system, on an equal basis with other Israelis. He wondered why the Health Assembly engaged in a detailed discussion of the situation in the West Bank, the Gaza Strip and the Golan Heights, but remained silent with regard to health conditions in the Syrian Arab Republic and Yemen, for example. The present discussion was absurd and should not be repeated. He called for a roll-call vote on the decision and urged Member States to vote against it.

The representative of TUNISIA said that the separation wall, checkpoints and permit systems were making it difficult for patients, doctors and ambulances to reach hospitals. That denial of Palestinians' rights to adequate health care violated international human rights and humanitarian law. She condemned the attacks on health facilities in the West Bank and east Jerusalem as well as the psychological pressures faced by all Palestinians. Palestinians in Israeli prisons were denied access to basic health care, adequate nutrition and accommodation, and family visits, and suffered physical and psychological abuse. She noted the lack of access to clean water in the Gaza Strip and the West Bank. Such measures were violations of international humanitarian law and practice. She praised the efforts of WHO to improve the situation, called on WHO to intensify its work, and urged donors to continue their support. She expressed her support for the draft decision and urged other Member States to do likewise.

The representative of TURKEY said that his country was on the list of sponsors of the draft decision and encouraged Members States to support it. Human rights violations and settler violence undermined universal values, including the right to health. Key health concerns were linked to avoidable and preventable diseases; and rejected applications for permits to travel to east Jerusalem for hospital treatment had led to loss of life. Restrictions on the movement of health-care workers and goods and the blockade on the Gaza Strip were illegal, inhumane and unacceptable. Document A69/44 noted that the increase in mental health problems was to be expected in a population experiencing prolonged occupation. He condemned attacks against health-care facilities, personnel and patients. The efforts of WHO and other United Nations agencies to alleviate the suffering of Palestinians were commendable, though insufficient. Acknowledging that some aid sent by his country had been delivered, he recalled that his country had donated more than US\$ 370 million of humanitarian and development aid to Palestine since 2005 and US\$ 1.5 million to WHO's field office to provide health-care services.

The representative of CUBA said that constraints on freedom of movement as a result of the separation wall, the blockade and the use of permits was having a negative impact on the health of people in the occupied Palestinian territory. Searches by the security forces and violent acts against health-care facilities was of concern, as was the prevalence of mental illness. Action taken by WHO to improve the health situation was to be commended. Given the reported seriousness of the situation in

occupied Syrian Golan, WHO should be granted access to that area. He strongly supported the right of the Palestinian people to establish an independent State and demanded that Israel should return all occupied territories. He asked that his country be added to the list of sponsors of the draft decision.

The representative of ECUADOR said that her Government remained deeply concerned about the flagrant violation of the right of the Palestinian people to enjoy the highest attainable standard of health, and the numerous continued and systematic violations of human rights and international humanitarian law committed by the occupying forces, which constituted a humanitarian emergency. She condemned the restrictions on access to health-care services imposed on those living in the occupied territories, especially as a result of the blockade on the Gaza Strip, the separation wall and the complex permit system. Her Government strongly supported the draft decision and wished to be added to the list of sponsors. WHO should continue to report on the health conditions in the occupied Palestinian territory and provide technical and financial support to strengthen the Palestinian health system, with a particular focus on the health needs of political prisoners in Israeli prisons.

The representative of the ISLAMIC REPUBLIC OF IRAN said that people in the West Bank and east Jerusalem were particularly vulnerable to pressures including social isolation, residency restrictions and threats of violence. The separation wall, checkpoints and permit requirements could prevent patients, health-care personnel and ambulances from accessing hospitals in east Jerusalem and had resulted in delays to or denial of health-care services. Widespread damage to essential infrastructure had significantly limited access to basic services in violation of international humanitarian law and contravening WHO's Constitution. The Organization should systematically monitor the health and humanitarian needs of Palestinian prisoners held in Israeli jails and report regularly thereon to the Health Assembly. It was of serious concern that WHO still did not have access to the occupied Syrian Golan and thus could not report on health conditions there. The international community should act urgently and collectively to require Israel to lift the restrictions currently in force. He expressed his reservation regarding those parts of the draft decision that might be construed as recognition of the Israeli regime.

The representative of INDONESIA expressed grave concern that people in need were often being denied health-care services because of border closures and restrictions on freedom of movement. Her Government had hosted a summit in March 2016 at which specific steps to achieve peace had been identified. Acknowledging the need for assistance from the international community, Indonesia had been providing training and funding for capacity building. She commended WHO's work in the occupied Palestinian territory and the occupied Syrian Golan, although the Organization's technical assistance programmes could be expanded. She supported the draft decision.

The representative of SOUTH AFRICA expressed concern about the deteriorating socioeconomic and health conditions in the occupied Palestinian territory, and commended the efforts of relevant United Nations agencies and WHO to provide assistance to the Palestinian people. The basic principles of human rights and international humanitarian law continued to be ignored, and Palestinian patients were denied access to health care. He urged Israel to lift all restrictions preventing the free movement of people, and stressed the need to implement resolution WHA65.9 (2012) on the health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan. His Government supported the draft decision.

The observer of PALESTINE said that the health sector was facing a range of health problems, including the recent poliomyelitis outbreak, and stressed that no immunization campaign could succeed without the participation of Israel. Israeli checkpoints hindered the provision and monitoring of health-care services. Ambulances were sometimes stopped or delayed, and hospitals were attacked, putting lives at risk. The separation wall had isolated a quarter of a million people, depriving many of their livelihoods, increasing poverty levels and hindering access to health and other basic services.

Shortages in water, electricity and fuel affected access to essential treatment. Moreover, the oil burned as an alternative source of fuel polluted the environment and produced carcinogenic fumes. Israeli prison clinics often failed to provide adequate levels of health care to Palestinian prisoners, and Palestinians receiving treatment in Israel had to pay for their health care. He called for an end to the Israeli occupation, and stressed the need for free access to health care and coordinated efforts to combat disease.

The representative of 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. The situation had been aggravated by deteriorating socioeconomic and health conditions resulting from the Israeli occupation, including the blockade on the Gaza Strip. The financial crisis affecting the Palestinian authorities also had a negative impact on the quality and scope of the services provided by the Palestinian Ministry of Health. Recalling the various resolutions adopted by the African Union, he called for all restrictions to be lifted so as to grant WHO access to the occupied Syrian Golan. He drew attention to the living and health conditions of Palestinian prisoners, especially women and children, which violated international human rights law. He welcomed the efforts of the Organization, in cooperation with partners, to provide support to the Palestinian Ministry of Health. There was an urgent need to resolve the health crisis in the region, in order to meet the basic health needs of the Palestinian people. He supported the draft decision.

The representative of the UNITED STATES OF AMERICA said that the current draft decision was not consistent with the shared objective of a Health Assembly focused purely on public health that refrained from singling out countries on a political basis. Serious concerns remained about conditions in the area, particularly in the Gaza Strip, but the draft decision would not lead to an improved health situation. His Government would continue to work with Israel, the Palestinians and others to meet the needs of the Palestinian people through its development assistance programmes. It was the largest donor to UNRWA and would continue to support that Agency's work. He supported the representative of Israel's call for a vote on the draft decision, which he would be voting against.

The representative of the SYRIAN ARAB REPUBLIC said that, despite repeated calls to improve health conditions in the occupied Syrian Golan, Israeli forces continued to engage in illegal and immoral practices, denying Syrians access to health-care services in an attempt to exert pressure on people who rejected Israeli identity. There was a lack of access to integrated health centres in the Golan area, with a particularly negative impact on the health of infants, young children, pregnant women and the elderly. He stressed the urgent need for integrated health services in the occupied Syrian Golan. Israel was attempting to mask its continuing occupation of the Syrian Golan and the support it was providing to terrorist groups in the occupied Golan, in violation of international law. The war against terror in the Syrian Arab Republic did not negate the right of the people of the occupied Golan to freedom, or alter the legal status of the Syrian Golan as an occupied territory.

The representative of LEBANON expressed support for the draft decision, which served as a reminder of the difficult health conditions in the occupied Syrian Golan and the occupied Palestinian territory, which continued to deteriorate under Israeli occupation. The restrictions on movement imposed by Israel had restricted access to health care, thereby contributing to a heavy burden of disease, with particular regard to noncommunicable diseases. Harmful Israeli practices, including acts of violence, had a negative impact on the physical and mental health of Palestinians. She congratulated WHO and its partners on their efforts, despite the lack of financial and technical resources, and reiterated that the plight of the Palestinian people should remain at the top of the international agenda.

The representative of MALDIVES said that the persistent blockade of goods and materials, military action, and the implementation of a system of apartheid were causing basic human rights and needs to be ignored in the occupied territories; the results included poor access to health care and severe water shortages. She called on Israel to cease all actions that hindered access to health services or humanitarian assistance or destroyed infrastructure, and condemned its persistent human rights violations in the occupied Palestinian territory. Her Government supported the draft decision and urged other Member States to do likewise.

The representative of KUWAIT, speaking on behalf of the Arab Group, recalled that health was enshrined in WHO's Constitution as a fundamental right for all, the achievement of which required cooperation. When preparing the proposed report for consideration at the Seventieth World Health Assembly the Secretariat should provide detailed information on: the restrictions on the movement of Palestinians; the safety and security of health infrastructure and ambulances; the health rights of Palestinians inside Israeli prisons, especially women and children; the rehabilitation of freed prisoners; detention conditions, especially of children; access to food, water, sanitation and medicines, particularly in the Gaza Strip; physical and mental health conditions; human rights violations; and conditions in the occupied Syrian Golan. He supported the draft decision.

The representative of CANADA expressed concern at the inclusion of such a political draft decision at the Health Assembly. There should be no room for politicization within a specialized agency of the United Nations. His Government considered it inappropriate that the draft decision singled out only one side for criticism and called for a one-sided approach. For those reasons, he was unable to support the draft decision.

The representative of NICARAGUA said that the reports dispelled any doubts about the gravity of the health problems caused by the occupation of the Palestinian territory. He condemned attacks against the Palestinian people, rejected the impunity enjoyed by Israel, and demanded an immediate end to hostilities in the region and the return of the occupied territory to the Palestinian people. He supported any initiative aimed at improving the health and humanitarian situation of the Palestinian people and promoting peace in the region. He asked that his country be added to the list of sponsors of the draft decision.

The representative of SAUDI ARABIA, noting poor access to health care and services, reiterated that the right to health was a fundamental human right, and encouraged international cooperation to change the reality on the ground. Many Palestinians in camps and prisons had been suffering for a long time and had been deprived of their fundamental rights. Access to health care in the occupied Palestinian territory was severely limited because of extreme poverty, the blockade on supplies, and attacks on ambulances and hospitals. He supported the draft decision and called on all Member States to support it.

The representative of the PLURINATIONAL STATE OF BOLIVIA acknowledged the poor socioeconomic, health and humanitarian situation of the Palestinian people, including resulting mental health disorders. Restrictions on free movement were unacceptable and prevented access to health-care services, and water. He urged the occupying Power to ensure access to health services and medical supplies. He welcomed WHO's efforts to monitor, improve and enhance public health capacity in the region. Expressing strong support for the draft decision, he urged all member States to support its adoption.

The representative of BANGLADESH expressed concern at the deteriorating health conditions in the occupied Palestinian territory and the occupied Syrian Golan, which constituted a humanitarian crisis. He welcomed the Organization's promotion of access to health in the region, and called for enhanced international cooperation to address growing health needs. He supported the draft decision

and was in favour of WHO providing enhanced technical assistance to improve health conditions in Palestine.

The representative of IRAQ said that the health situation was deteriorating in the occupied Palestinian territory and the occupied Syrian Golan, with particular regard to restrictions on the movement of patients and access to health care and ambulances. In addition, there were shortages in budget allocations and financial resources. He supported the draft decision as it was important for WHO to address the issue and for the international community to show its support for the Palestinian people.

The representative of JORDAN said that the field assessment report clearly showed that Israeli practices were violating international humanitarian law, and he called for an end to the Israeli occupation of the occupied Palestinian territory. Israel's checkpoints and the separation wall hindered access to health care; and the Palestinian people faced the threat of enforced displacement and eviction. The longer the occupation continued, the greater the impact would be on health, human rights and the environment. He called on WHO to bolster support for health systems in the territory while enhancing preparedness and the monitoring of health emergencies. He supported the draft decision.

The DIRECTOR OF HEALTH (UNRWA) said that the health of Palestinian refugees was a cause for concern. Refugees accounted for almost 50% of the population of the occupied Palestinian territory. UNRWA continued to provide health care through 65 health centres. Recent reforms, including the introduction of family health teams and the implementation of electronic medical records, had contributed to improving primary health care. The support of host countries, donors and international partners was appreciated. Poverty in the occupied Palestinian territory had contributed to a rise in noncommunicable diseases, and conflict had had a profound impact on mental health and psychosocial well-being, particularly that of children. Political instability, threats of violence, unemployment and a poor human rights record all affected the health situation in the occupied Palestinian territory. UNRWA was committed to protecting and providing support to Palestinian refugees, despite financial difficulties, and he urged the international community to continue to support the Palestinian people.

The CHAIRMAN said that, at the request of the representative of Israel, supported by the representative of the United States of America, the Committee would proceed to a recorded vote on the draft decision.

At the invitation of the CHAIRMAN, the LEGAL COUNSEL explained that the vote would be taken by roll-call, in accordance with Rule 72 of the Rules of Procedure of the World Health Assembly. The names of the Member States would be called in the French alphabetical order, starting with Saint Kitts and Nevis, the letter S having been determined by lot. 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: Central African Republic, Comoros, Dominica, Guinea, Guinea-Bissau, Guyana, Nauru, Niue, Saint Lucia, Somalia, Trinidad and Tobago, Ukraine and Yemen.

The result of the vote was:

In favour: Afghanistan, Albania, Algeria, Andorra, Argentina, Austria, Azerbaijan, Bahrain, Bangladesh, Belarus, Belgium, Benin, Bhutan, Bolivia (Plurinational State of), Brazil, Brunei Darussalam, Bulgaria, Burundi, Cabo Verde, Cambodia, Chile, China, Congo, Costa Rica, Croatia, Cuba, Cyprus, Czech Republic, Denmark, Djibouti, Dominican Republic, Ecuador, Egypt, El Salvador, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, India, Indonesia, Iran (Islamic Republic of), Iraq, Ireland, Italy, Jamaica, Japan, Jordan, Kazakhstan,

Kuwait, Latvia, Lebanon, Liberia, Lithuania, Luxembourg, Malaysia, Maldives, Mali, Malta, Mauritania, Mexico, Monaco, Montenegro, Morocco, Namibia, Netherlands, Nicaragua, Niger, Nigeria, Norway, Oman, Pakistan, Panama, Peru, Philippines, Poland, Portugal, Qatar, Republic of Korea, Republic of Moldova, Romania, Russian Federation, Saudi Arabia, Senegal, Serbia, Singapore, Slovakia, Slovenia, South Africa, Spain, Sri Lanka, Sweden, Switzerland, Syrian Arab Republic, Thailand, the former Yugoslav Republic of Macedonia, Tunisia, Turkey, United Arab Emirates, United Kingdom of Great Britain and Northern Ireland, Uruguay, Uzbekistan, Venezuela (Bolivarian Republic of), Viet Nam, Zimbabwe.

Against: Australia, Canada, Guatemala, Israel, Micronesia (Federated States of), Papua New Guinea, Paraguay, United States of America.

Abstaining: Armenia, Cameroon, Colombia, Democratic Republic of the Congo, Fiji, Ghana, Honduras, New Zealand.

Absent: Angola, Antigua and Barbuda, Bahamas, Barbados, Belize, Bosnia and Herzegovina, Botswana, Burkina Faso, Chad, Cook Islands, Côte d'Ivoire, Democratic People's Republic of Korea, Equatorial Guinea, Eritrea, Ethiopia, Gabon, Gambia, Georgia, Grenada, Haiti, Kenya, Kiribati, Kyrgyzstan, Lao People's Democratic Republic, Lesotho, Libya, Madagascar, Malawi, Marshall Islands, Mauritius, Mongolia, Mozambique, Myanmar, Nepal, Palau, Rwanda, Saint Kitts and Nevis, Saint Vincent and the Grenadines, Samoa, San Marino, Sao Tome and Principe, Seychelles, Sierra Leone, Solomon Islands, South Sudan, Sudan, Suriname, Swaziland, Tajikistan, Timor-Leste, Togo, Tonga, Turkmenistan, Tuvalu, Uganda, United Republic of Tanzania, Vanuatu, Zambia.

The draft decision was therefore approved by 107 votes to 8, with 8 abstentions.¹

The representative of NETHERLANDS, speaking on behalf of the European Union and its Member States and in explanation of vote, said that the European Union was of the view that the Health Assembly should remain a technical body and that the decision on health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan should therefore focus on technical considerations and on the requests made of the Director-General. Against that background, the European Union had supported the decision.

The representatives of EGYPT, the BOLIVARIAN REPUBLIC OF VENEZUELA and ALGERIA said that their countries wished to be added to the list of sponsors of the decision.

The representative of MOROCCO said that his country wished to be added to the list of supporters of the decision.

¹ Transmitted to the Health Assembly in the Committee's first report and adopted as decision WHA69(10).

4. HEALTH SYSTEMS: Item 16 of the agenda [transferred from Committee A]¹

Follow-up to the report of the Consultative Expert Working Group on Research and Development: Financing and Coordination – Report of the open-ended meeting of Member States: Item 16.2 of the agenda (document A69/40)

The CHAIRMAN informed the Committee that Dr Prakash (India) had been nominated as chairman of the drafting group that had been established to finalize the text of the draft decision contained in document A69/40.

It was so agreed.

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

The meeting rose at 17:30.

¹ See summary record of the General Committee, first meeting, section 2.

SECOND MEETING

Thursday, 26 May 2016, at 09:20

Chairman: Dr PHUSIT PRAKONGSAI (Thailand)

1. PROGRAMME BUDGET AND FINANCIAL MATTERS: Item 20 of the agenda

WHO programmatic and financial report for 2014–2015 including audited financial statements for 2015: Item 20.1 of the agenda (documents A69/45, A69/62 and A69/INF./3)

The representative of the UNITED KINGDOM OF GREAT BRITAIN AND NORTHERN IRELAND, speaking in her capacity as Chairman of the Programme, Budget and Administration Committee of the Executive Board, presented the report on the Committee's consideration of the WHO programmatic and financial report. The Committee's report (document A69/62) contained a draft resolution recommended for adoption by the Health Assembly.

The representative of SWEDEN, speaking on behalf of the Nordic and Baltic countries Denmark, Estonia, Finland, Iceland, Latvia, Lithuania, Norway and Sweden, commended the introduction of a unified programmatic and financial report, which provided a more coherent assessment of targets, financing and results and their alignment with the agreed programme budget. She urged the Secretariat to continue to develop the unified report format in order to strengthen those links.

She expressed concern, however, that only 29% of available funds were flexible, as the base segment of the budget relied heavily on flexible financing. Furthermore, despite an overall increase in voluntary contributions, the proportion that were flexible had decreased by 7%; the remainder were earmarked and came with reporting requirements, which could undermine implementation of the agreed programme budget and create an undue reporting burden. She asked whether the trend looked set to continue and whether it would affect programme budget delivery.

She urged WHO to build on the substantial results achieved through the financing dialogue, in particular with respect to the planned special funding sessions for the WHO Health Emergencies Programme, and not to undermine the general strategic approach taken, so as to ensure that the agreed programme budget would be fully funded.

The representative of the UNITED KINGDOM OF GREAT BRITAIN AND NORTHERN IRELAND expressed the hope that the new, combined format of the programmatic and financial report would become standard practice. The updated programme budget web portal represented a major improvement in transparency. She welcomed the proposal to harmonize reporting against WHO's commitments to deliver reforms.

The representative of CHINA endorsed the new approach taken in the combined programmatic and financial report since it allowed a more rounded evaluation of performance and brought new knowledge and perspectives. As evidenced by funding levels for 2014–2015 and 2016–2017, reform was delivering results; nevertheless, it was a matter of concern that flexible voluntary contributions were decreasing while earmarked voluntary contributions had increased. In certain areas, even sufficient funding had failed to deliver satisfactory results. Future reports should include a comparative analysis of outputs achieved and percentage of budget allocation spent so as to improve the design of targets and use funds more efficiently. She expressed support for the draft resolution.

The representative of THAILAND welcomed the detailed programmatic and financial report and expressed appreciation for the accountability and transparency provided by both the unified report and the programme budget web portal. The involvement of Member States in the programme budget implementation cycle was crucial to ensuring that realities were reflected and health concerns were addressed. In order to improve assessment, she encouraged the Secretariat: to develop the monitoring and evaluation framework, including a systematic monitoring mechanism to verify output indicators, deliverables and outcomes; to take action to achieve the desired results; and to prepare guidance for the next planning cycle.

The representative of GERMANY commended the excellent level of detail and information provided in the programmatic and financial report. Although spending at the country level had increased to 52% of total expenditure, there was still no systematic process for matching country office capacities to the changing needs at the country level; he asked how fully flexible resources were distributed among the seven major offices. He expressed concern that the decrease in flexible core voluntary contributions might be a reaction to the failure to strengthen accountability throughout the three levels of the Organization, with donors preferring to ensure direct accountability by earmarking their contributions. It was also troubling that 71% of Member State contributions came from only 10 Member States: such a dramatic imbalance must be addressed because dependence on a small donor base and the uncertainty of long-term funding posed the greatest risks to the Organization. The Secretariat should think strategically about how to address that challenge.

The potential elimination of poliomyelitis, progress towards which was a great success, would entail significant financial and structural risk, given the high proportion of funding currently allocated to such activities. It was unrealistic to expect that donors would contribute similar amounts to other health issues, and the Organization should take appropriate steps to prepare for that scenario. With regard to the Organization's most significant long-term staff liability – after-service health care costs – he asked whether coverage under the WHO staff health insurance scheme for staff of other entities was cost-neutral to the Organization and whether those entities had contributed to setting aside adequate assets.

The representative of MEXICO endorsed the approach taken in the programmatic and financial report to align the global impact goals in the Twelfth General Programme of Work, 2014–2019, with the work achieved on the Millennium Development Goals in 2015. The new format of the report contributed to strengthening transparency and accountability for the funds used and expected results. It must be ensured that no gap was left in information when separate reports were combined and that reports were published sufficiently early to allow for them to be studied with due care and attention.

The representative of IRAQ, highlighting the challenge of making the Organization's work more effective and more transparent, suggested that financial reports should be submitted every six months. It was important for Member States' opinions to be taken into account so as to ensure more thorough and accurate evaluations. Better communication between Member States and the Secretariat would enhance Member State participation in the Organization's work and make reforms more effective.

The ASSISTANT DIRECTOR-GENERAL (General Management) said that the combined reporting format, the strong support for which he acknowledged, was part of the WHO reform process, allowing Member States to link their financial investments with programmatic results. The Secretariat would continue to use the new format and to refine it over time.

He shared the concerns expressed about the decrease in flexible funds but assured the Committee that, as a result of the Director-General's new budget management policy, they had been used more strategically and therefore no programme area had suffered a financial shortfall during the biennium. A decrease in such funds would complicate their strategic use and the issue would be discussed with donors and Member States to see how it could be resolved. Future financing was a

long-term risk; although the budget for the present biennium appeared to be fully funded, the position looked less certain from 2018–2019 onwards. The situation was particularly worrying with respect to staff costs: a long-term liability which represented between 40% and 50% of the Organization's expenditure. Efforts must be made, with Member States and through the financing dialogue, to ensure appropriate funding of staff costs and activity costs.

He would follow through on the excellent recommendation by the representative of China to improve the comparative analysis of outputs achieved and the percentage of budget allocation spent. He agreed with the representatives of Thailand and the United Kingdom on the importance of harmonized reporting, monitoring and evaluation, which the Organization would take forward from 2017 in a more holistic way. With respect to the questions by the representative of Germany, flexible funds were allocated by the Global Policy Group based on recommendations from programme and category networks. A report would be submitted to the Executive Board in January 2017 on the impact of any reduction in funding as a result of the potential eradication of poliomyelitis. Reports on the Organization's staff health insurance liability were submitted directly to the Executive Board and through the Independent Expert Oversight Advisory Committee. All entities covered by the WHO staff health insurance programme did their part to ensure that adequate assets were set aside. The programme was monitored by the Organization. Although resources would not allow for full financial reports to be published every six months, regular updates would be provided through the web portal.

The CHAIRMAN took it that the Committee agreed to approve the draft resolution contained in document A69/62.

The draft resolution was approved.¹

Financing of Programme budget 2016–2017: Item 20.2 of the agenda (document A69/46)

- **Strategic budget space allocation** (documents A69/47 and EB137/2015/REC/1, decision EB137(7))

The representative of the UNITED STATES OF AMERICA welcomed efforts to strengthen financing reform and to widen the Organization's donor base, including non-State actors. Although her country could not provide fully flexible voluntary contributions, it sought to be as flexible as possible in its earmarking. Commending the financing dialogue and the four-pillar strategy outlined, she encouraged further work to ensure more predictable and flexible financing aligned with the Organization's Twelfth General Programme of Work and strategic priorities.

The representative of CAMEROON, welcoming the increased predictability of funding resulting from the financing dialogue, emphasized the need for irreproachable financial governance in the face of slower growth in the major economies, ever greater health needs and increasing requirements in terms of transparency, effectiveness and performance. Achieving the target of universal health coverage, included among the goals of the 2030 Agenda for Sustainable Development, would require the Organization to consolidate its position as a strategic leader in developing technical and financial synergies.

The representative of CHINA said that the financing dialogue had already begun to improve the status of the financing of the programme budget. However, despite the encouraging perspective for financing for the biennium 2016–2017, the mid-term prospect was still worrying. He supported the report's proposed responses to remaining challenges but noted that no solution had been put forward for the most important issue: the flexibility of voluntary contributions. He requested that WHO should

¹ Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA69.12.

consider lifting the freeze on assessed contributions, as small but constant increases would improve WHO's budget structure and make funding more flexible. His Government supported adopting the model proposed by the Working Group on the Strategic Budget Space Allocation because its indicators and calculations resolved problems in the current model and would minimize any negative impact on regional and country-level budgets. He agreed with paragraph (3) of the decision recommended in decision EB137(7)¹ and stressed that during the periodic reviews the principle expressed in subparagraph 3(a) must be implemented and maintained.

The representative of SOUTH AFRICA said that WHO's commitment to joining the International Aid Transparency Initiative by the end of 2016 was encouraging; she requested updates on that objective. It was nonetheless worrying that alignment of funding across the programme budget had not been achieved. She welcomed the outlined four-pillar strategy and supported the establishment of the Department for Coordinated Resource Allocation within the Director-General's office. She commended the reporting framework which linked funds to predetermined, measurable objectives.

The representative of THAILAND expressed support for China's statement and proposal. Strictly earmarked voluntary contributions and a limited number of voluntary contributors were a concern and could cause uncertainty for WHO's budget. The new WHO Health Emergencies Programme, to be established during the current biennium, would also make more voluntary contributions necessary; she requested that the financial consequences of that Programme should be assessed and included in the next report on the Programme budget 2016–2017. She welcomed the new model recommended by the Working Group on the Strategic Budget Space Allocation, which would have the least impact on the programme budgets of the six regions. WHO should use its social and intellectual capital at regional and country levels to mobilize additional resources to support implementation of national activities. She supported the draft decision.

The representative of MALDIVES acknowledged the value of the financing dialogue and welcomed the outlined four-pillar strategy to deal with the remaining challenges. The Director-General's strategic use of flexible funds had enhanced the already high level of alignment at the category level. Funding should be better aligned, however, and vulnerabilities reduced to better reflect the priorities set by Member States. She urged the Secretariat to continue to address persisting problems, particularly excessive earmarking and the dependence on only a few voluntary contributors.

The representative of FRANCE welcomed document A69/46, noting in particular that the base budget enabled funding of WHO's six main categories of work and that a sum of nearly US\$ 1200 million, relying exclusively on voluntary contributions, was budgeted separately for outbreak and crisis response, poliomyelitis eradication and research on tropical diseases and human reproduction. She requested further details on the full resource-mobilization process instituted in 2016 and how it would improve coordination Organization-wide. She supported the more strategic use of flexible voluntary contributions; resources should be used according to the priorities set by Member States. Voluntary contributions must be made more flexible; the US\$ 250 million of flexible voluntary contributions for the current biennium was insufficient.

The representative of GERMANY asked why the mid-term perspective was described as worrying (document A69/46, paragraph 5) and what concrete factors had led to that conclusion. He did not agree with the assessment (paragraph 9) that the level of flexible voluntary contributions had remained stable, as it had fallen compared with the previous biennium; an update on the outlook for the current year would be welcome. The assertion about the alignment of financing in paragraph 10 was confusing, as base programmes were at least 96% funded according to the financial report on the

¹ Reproduced in document A69/47.

previous biennium: thus, full alignment should have been reached. He strongly supported the proposed reporting reform in time for the next financial dialogue, in particular streamlining the 3000 different reports submitted annually, in order to reduce the burden on the Secretariat and save financial and human resources for global health challenges.

He had expected the report to include information on how much funding had already been secured and a clear presentation of which areas were fully- or under-funded, as that would have been helpful in steering money to where it was needed most and in ensuring Organization-wide alignment. He encouraged the Secretariat to provide such information as soon as possible.

The representative of INDONESIA considered the new budget space allocation method to be strategic and practical in that it included essential health indicators and took into account regional priorities and countries' demographic and geographical characteristics. He supported the claims that the South-East Asia Region deserved a larger share of the programme budget than other regions as it had a greater disease burden and was more vulnerable to natural disasters, epidemics and pandemics. The allocation process must nonetheless reflect the principle of equality.

The representative of the REPUBLIC OF KOREA said that the financing dialogue had been helpful for understanding WHO's commitment to reform and identifying its priorities for projects. Better transparency and accountability would help to expand the contributor base for the long term; she agreed that securing multi-year funding and flexible voluntary contributions would be crucial for the predictability of WHO project budgets. Implementation would not be easy, however, owing to various factors. Expanding the donor base could also lead to an increase in donor-related vulnerability, which WHO must continue to keep in check. Her Government supported the proposal to adopt the decision on budget space allocation and would join efforts to ensure its full implementation.

The representative of MEXICO underscored the importance of strengthening resource mobilization and flexible financing so as not to leave vulnerable programme areas behind or create budget deficits. It was necessary to respond to existing problems without creating more bureaucracy. Resource mobilization should be based on specific priorities, which should be clearly identified in the programme budget web portal. Reducing vulnerability in budget financing was also important, as expressed in paragraph 18 of the report. Mexico had participated in the Working Group and stressed that the Group had borne in mind the specific needs of each region. The scientific basis of the proposed model would contribute to greater transparency, fairness and accountability at WHO.

The representative of MALAYSIA expressed appreciation to the Working Group and the external advisors for developing the revised model for strategic budget space allocation. Although he supported adoption of the new model, the regions must reflect on how best to allocate their budget envelopes to individual countries based on a standard performance metric.

The representative of CAMEROON, speaking on behalf of the Member States of the African Region, praised the depth of analysis and overall quality of the documents produced by the Working Group on the Strategic Budget Space Allocation. The decision recommended for adoption in decision EB137(7) represented part of a laudable trend of increasing transparency in WHO's financial management, and the Health Assembly should adopt it.

The ASSISTANT DIRECTOR-GENERAL (General Management) ascribed recent improvements in financial management to several developments: the financing dialogue, which had helped in establishing mutual trust and communication between the Secretariat, Member States and other donors; the web portal, which had increased transparency and would henceforth provide updates on both financial and programme results each quarter; adoption of a corporate approach; and continuing internal and external dialogues. Excessive earmarking of voluntary contributions was problematic; although early in a biennium, that was not a problem, more flexibility was always needed

once it became clear which areas were underfunded. The approach taken by the Government of Sweden provided a good solution: they had invited the Secretariat to inform them if a given programme was overfunded so that they could reallocate their contribution.

At the 138th session of the Executive Board, the Director-General had committed WHO to joining the International Aid Transparency Initiative; an internal working group on the issue had met just before the Health Assembly and would report to the Executive Board in 2017. As for resource mobilization, it was coordinated on all three levels through a group composed of representatives from all levels and major offices. Thus, unlike in the past, discussions with donors were coordinated throughout the Organization. The impact of the new WHO Health Emergencies Programme on the programme budget would be reported via the web portal. Replying to the representative of Germany, he said that it was the global economic situation that made mid-term and long-term perspectives worrying, as a recession would affect multilateral agencies such as WHO. More immediate risks included staff costs for the Global Polio Eradication Initiative after 2019. There were also foreign-exchange and investment risks and long-term infrastructure needs. Any concerns would be discussed with Members at financing dialogues or governing body sessions. Information on over- and underfunded areas could be found on the web portal. Overall, programmatic and financial reporting for the biennium 2014–2015 had three congruent components: printed reports, the web portal and the WHO website. Finally, he congratulated the Working Group on the Strategic Budget Space Allocation for resolving a difficult and complicated issue in a manner acceptable to all.

The DIRECTOR-GENERAL, replying to the representative of China, said that Member States had called for a WHO reform focusing on budget discipline and transparency. Assessed contributions and voluntary contributions provided different advantages in terms of flexibility. A combined approach was an improvement on the previous practice of relying on an aspirational budget, where pledges were made but not always fulfilled. The financial reform sought to provide instruments that reported clearly on the link between the Organization's income and expenditure, and to bring about a cultural change in the Member States and Secretariat. The Secretariat needed to stop absorbing resources that could not be applied to the priorities outlined by Member States, as that could divert the Organization's attention away from those priorities. Both assessed and voluntary contributions could be effective when they matched priorities, but assessed contributions continued to offer greater flexibility than voluntary contributions in that they could be applied to underfunded critical areas. In the light of the financial difficulties caused by the 2008 financial crisis, the Organization sought to protect staff and the Organization as a whole by adopting a more sustainable approach. She acknowledged that assessed contributions required Member States to make considerable efforts, but the approach reflected their own calls for greater sustainability and predictability. Voluntary contributions could be useful to tide the Organization over while the financing dialogue was underway. However, in that dialogue, the Secretariat would highlight the importance of investing in the Organization through assessed contributions. The Proposed programme budget 2018–2019 would incorporate the outcomes of the financing dialogue, to be held after the current Health Assembly. In order to allay concerns that an increase in assessed contributions would result in a transfer of funds away from certain important programmes, the "Delivering as One" initiatives would be ring-fenced. Reform would focus on setting out the priorities for resource implementation. In particular, she commended China's increase in its assessed contributions, while acknowledging the challenges that such a commitment presented for other countries. The financing dialogue would address the possibility of applying less earmarking to voluntary contributions to allow for reallocation within the same category level, rather than tying the Organization's hands.

The CHAIRMAN invited the Committee to consider the decision recommended in decision EB137(7).

The draft decision was approved.¹

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 A69/48 and A69/63)

The representative of THAILAND expressed appreciation for WHO's technical support to countries facing difficulties as a result of economic and social crises and encouraged the Organization to continue activities that provided benefits for all.

The CHAIRMAN announced that payments had been received from the following countries: Iraq, Lebanon, Saint Vincent and the Grenadines, Suriname and Swaziland. The names of those countries would therefore be deleted from the draft resolution. He invited the Committee to approve the draft resolution contained in document A69/63, as amended.

The draft resolution, as amended, was approved.²

Scale of assessments for 2017: Item 20.5 of the agenda (documents A69/49 and EB138/2016/REC/1, resolution EB138.R6)

The representative of CHINA said that China's contribution had risen from 5.94% to 7.92% despite the slow-down in its economy. Health activities were still ongoing but many challenges remained and would increase the need for financial investment. He confirmed China's firm support for WHO's role in promoting health worldwide, and its commitment to settling its contribution in accordance with the new scale of assessments. He supported the draft resolution.

The representative of THAILAND reaffirmed her Government's commitment to contributing to WHO on the basis of the scale of assessment for 2017.

The CHAIRMAN invited the Committee to consider the draft resolution contained in resolution EB138.R6.

The draft resolution was approved.³

2. FIRST REPORT OF COMMITTEE B (document A69/69)

The RAPPORTEUR read out the draft first report of Committee B.

The report was adopted.⁴

¹ Transmitted to the Health Assembly in the Committee's second report and adopted as decision WHA69(16).

² Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA69.13.

³ Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA69.14.

⁴ See page 383.

3. AUDIT AND OVERSIGHT MATTERS: Item 21 of the agenda

Report of the External Auditor: Item 21.1 of the agenda (documents A69/50 and A69/64)

The representative of the EXTERNAL AUDITOR introduced the report of the External Auditor (contained in document A69/50). The Organization's financial statements had been audited in accordance with the International Standards on Auditing. The audit had reviewed management controls in various offices in line with International Standard on Auditing 265, which defined the auditor's responsibility to communicate deficiencies in internal control appropriately with those charged with governance and management. The 2015 audit had covered various offices at headquarters, the Global Service Centre, one regional office, one inter-country support team, five country offices and six non-consolidated entities. It had resulted in the issuance of an unmodified opinion indicating that the Organization's financial statements were fairly presented in all material respects and it concluded that accounting policies were applied on a basis consistent with that of the preceding year. It found that the transactions that came to its notice complied with the Financial Regulations and legislative authority of WHO in all significant respects. She commended the cooperation and professionalism of the financial department in producing financial statements compliant with the International Public Sector Accounting Standards and the efforts to implement the recommendations issued in the course of the interim and year-end audits. The audit had, however, highlighted a number of issues that needed to be addressed, including the need to improve financial transactions recording, processing and reporting and to ensure the fair presentation of financial statements in the following reporting period. It had furthermore noted the work to be done in various areas such as the timely reporting of revenues, the roll-out of the Global Inventory Management System and the further improvement of the quality of data sources. The External Auditor had accordingly made a series of recommendations to the Secretariat, including a set of seven recommendations aimed at improving management control.

The representative of the UNITED STATES OF AMERICA said that reviews by the External Auditor were an important component of WHO's oversight mechanisms and she trusted that the findings and recommendations would be implemented in full. She agreed that travel costs should be appropriately controlled and asked what measures would be taken to strengthen monitoring and compliance regarding staff travel reporting parameters. She welcomed the External Auditor's observations regarding the evaluation of staff performance and sought information on the strategies that would be used to ensure adherence to the SMART criteria and compliance with the performance management and development system.

The representative of THAILAND said that implementation of the External Auditor's recommendations would strengthen coordination and resilience at all levels of the Organization. He was especially concerned about the many instances of weak direct financial cooperation management in the audited regions and the large number of overdue reports; he requested that the problems would be rectified in a comprehensive and systematic manner. He urged the Organization to expedite implementation of the External Auditor's recommendations contained in prior years' audit reports.

The representative of SPAIN said that it was crucial to strengthen WHO's oversight bodies in order to ensure a more efficient and effective use of resources. He expressed concern about the risks to the Organization posed by staff insurance and pension liabilities and requested that appropriate mitigation strategies should be developed and proposed to Member States. He acknowledged the comments by the Director-General regarding contributions: without doubt, flexible contributions would permit adequate funding of programmes. Nevertheless, to increase contribution levels in the current economic climate could pose difficulties for Member States and therefore he requested that the Secretariat should prepare a cost-reduction plan and seek new sources of funding.

He requested that the time between the end of the meeting of the Programme, Budget and Administration Committee and the start of the Health Assembly should be extended in order to allow Member States more time to consider financial and budgetary matters.

The representative of CHINA commended the objective report of the External Auditor, which would promote transparency, accountability and efficiency in the management of the Organization's financial and human resources, and fully supported the recommendations made with regard to ongoing asset and inventory, travel and direct financial cooperation management challenges. The Secretariat was urged to implement all the recommendations made in the report, and must redouble its efforts to achieve full implementation of the 10 external audit recommendations contained in prior years' audit reports.

The representative of SAO TOME AND PRINCIPE, speaking on behalf of the Member States of the African Region, expressed appreciation for the report of the External Auditor and supported the recommendations contained therein.

The representative of the UNITED KINGDOM OF GREAT BRITAIN AND NORTHERN IRELAND welcomed the unmodified audit opinion. She noted with concern that the reports of the Internal Auditor, the External Auditor and the Independent Expert Oversight Advisory Committee had all underscored the need to strengthen internal controls with a view to managing the risks faced by the Organization and had stressed the need to enforce sanctions for non-compliance with internal controls. She recognized that WHO worked in many complex and uncertain situations, but it was very important that management of the Organization's finances, human resources and risk should be improved so that it could deliver the priorities and maintain the confidence of its partners. Like all Member States, the United Kingdom was committed to ensuring that taxpayer-funded contributions to WHO were properly accounted for and used to maximum effect. Fraud and misuse of funds could not be tolerated. The Secretariat should pay strong attention to the audit recommendations, particularly those that could have the greatest impact on the Organization's effectiveness, and it must also ascertain whether implementation of the recommendations had solved the underlying problems that they were supposed to address. The Secretariat should, moreover, make use of its online reform dashboard to track and report on implementation of the audit recommendations.

The representative of FRANCE called on the Secretariat to implement the recommendations contained in the report in full and at the earliest opportunity. It should, moreover, accelerate implementation of the recommendations contained in prior years' audit reports. She proposed extending the mandate of the External Auditor from four or six years, so that it covered at least two full budget bienniums, as that would allow the External Auditor to gain a more in-depth understanding of the challenges of the audit process as they related to the Organization.

The representative of MEXICO urged the Secretariat to implement the recommendations made in the report of the External Auditor at the earliest opportunity. Internal auditing mechanisms must be strengthened and the duties and responsibilities of staff members clearly defined with a view to improving transparency and accountability. She noted with concern the lack of standardized procurement planning and recommended that the situation should be reviewed and procedures implemented in order to improve efficient use of resources. She requested that a detailed plan should be put in place in order to address the management weaknesses in direct financial cooperation. Implementation of the recommendations made in the report should be aligned with the recommendations made by other oversight bodies and the status of implementation of past recommendations should be included in future reports so as not to lose sight of them.

The ASSISTANT DIRECTOR-GENERAL (General Management) gave his assurances that the Secretariat prioritized audit recommendations both in collaboration with the Independent Expert Oversight Advisory Committee and on an internal basis. He agreed that more could be done to evaluate whether implementation of recommendations had solved the underlying problems which they had been designed to address. WHO was committed to enhancing transparency by tracking and reporting on the implementation of audit recommendations on the online reform dashboard. The issue of travel management was taken seriously: pre- and post-travel oversight procedures had already been strengthened and a revised duty-travel policy would be finalized by the end of 2016. The Secretariat was also seeking to enhance compliance with the performance management and development system, which had been included in the accountability compact between the Director-General and the Assistant Directors-General and included in the online dashboard. Supervisors were obliged to provide feedback to their staff with a view to optimizing performance.

The number of overdue reports on direct financial cooperation had been substantially reduced and further progress would be assisted if all country counterparts could submit their reports to the Organization on time.

The Secretariat would continue to seek ways to reduce costs and to enhance cost-efficiency and took seriously the calls by the Internal Auditor, the External Auditor and the Independent Expert Oversight Advisory Committee for stronger internal control mechanisms. The Organization had the lowest-ever number of outstanding audit recommendations at the present time and the regional directors were strongly committed to internal control and compliance.

With regard to the proposal to extend the mandate of the External Auditor to six years, he explained that four-year terms were the norm among organizations in the United Nations system. The mandate could only be extended pursuant to the adoption of a resolution by the Health Assembly.

The representative of the EXTERNAL AUDITOR affirmed the commitment to fulfilling the renewed mandate of the External Auditor with independence, integrity, resoluteness and a high-level of competence, and to fostering a vibrant partnership with the Secretariat.

The CHAIRMAN took it that the Committee agreed to approve the draft resolution contained in document A69/64.

The draft resolution was approved.¹

Report of the Internal Auditor: Item 21.2 of the agenda (documents A69/51 and A69/64)

The representative of the UNITED KINGDOM OF GREAT BRITAIN AND NORTHERN IRELAND, speaking in her capacity as Chairman of the Programme, Budget and Administration Committee of the Executive Board, introduced the report of the Committee's consideration of the item (document A69/64). The Committee, on behalf of the Executive Board, had recommended that the Health Assembly should note the report of the Internal Auditor.

The representative of THAILAND said that in order for WHO to fulfil its mandate effectively, it was crucial to improve risk management, enhance controls and strengthen governance mechanisms. Compliance issues that had occurred during the Ebola virus disease outbreak had made clear that WHO needed effective standard operating procedures and a clear decision-making structure to handle future emergencies. The rise by some 66% in 2015 in incidences of alleged misconduct by WHO staff members undermined the credibility of the Organization. The Secretariat must strengthen its policy of zero tolerance for non-compliance and ensure that that policy was implemented at all levels of performance management. Although the general improvement in effective controls was welcome, he

¹ Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA69.15.

expressed concern that internal controls remained weak in several areas, including global management systems, information technology, security and the procurement of goods and services at the country level, and that control compliance was enforced unevenly across the Organization.

The representative of the UNITED KINGDOM OF GREAT BRITAIN AND NORTHERN IRELAND reiterated the concerns she had raised in the discussion of the previous agenda item regarding internal controls: they were equally applicable to the current discussion. In order to deliver on its priorities, the Secretariat must continue to strengthen internal controls and embed a positive culture of compliance. In view of the many years it would take to complete a full audit of all WHO offices, she proposed that the Secretariat should consider a prioritized approach to audit investigations that would focus on specific compliance themes in a number of high-risk locations. She further proposed that the Secretariat should define its risk appetite, by determining the levels of risk it was prepared to accept in different spheres of its work and communicating them to its staff.

The representative of AUSTRALIA welcomed the practical approach of the Office of Internal Oversight Services to risk management, control and governance. He emphasized the importance of ensuring independent validation of data from self-assessments as that would enhance the credibility of WHO's performance reporting. He expressed concern that the operating effectiveness of internal controls had diminished and strongly urged all levels of the Organization to embrace the framework. Clear communication of the steps needed to implement the new initiative might result in speedier observable change. He was also concerned about the increase in reports of suspected wrongdoing and sought an analysis of the problem: the priority should be to engage a sufficient number of qualified investigators to tackle the backlog of cases. The audit recommendations should be implemented swiftly to ensure the most efficient use of WHO's resources.

The representative of CHINA drew attention to the continuing problems with budgeting and compliance in emergency management, as the response to the Ebola virus disease outbreak had shown, and urged the Secretariat to reform its budget planning and comply with emergency norms. She urged the Secretariat also to accelerate implementation of the audit recommendations. The audits at country level showed that the effectiveness of internal controls was a matter of concern. She fully supported the recommendations of the Office of Internal Oversight Services, and asked the Health Assembly to adopt and implement them.

The representative of GERMANY said that strengthening of internal controls and compliance remained a priority for his Government and stressed that, in a highly decentralized organization such as WHO, adequate resources had to be invested in internal controls. He asked what percentage of WHO's overall funding was spent on controls and whether the Secretariat considered it adequate, in particular in comparison with other United Nations agencies. He expressed concern that the speed of cultural change remained too slow. He was not convinced that WHO was equipped to deal with all significant allegations of wrongdoing, bearing in mind the increase in their number and that the whistle-blower hotline was likely to bring still more. He asked whether compliance failures had practical consequences for staff members, what procedure were in place to set priorities among the large number of allegations, and what mechanisms were applied to identify frivolous or groundless allegations. The same investigative procedures should apply to staff members at every level and those procedures should be made publicly available to ensure that staff members knew that they were being respected. It would be useful to have a breakdown of investigations by type of wrongdoing and by office.

The representative of FRANCE asked for details of what was being done to make controls more effective in the important areas in which they were still inadequate. She was especially concerned about the lack of effective controls regarding the procurement of goods and services, and direct

financial cooperation. She deplored the lack of any real improvement in compliance at every level of the Organization.

The representative of the UNITED STATES OF AMERICA said that her Government placed great value on effective internal oversight and she encouraged the Director-General to address swiftly the internal control weaknesses identified in the internal auditor's report. She expressed concern at the significant increase in reports of suspected wrongdoing and the backlog of investigations, and encouraged the Director-General to make every effort to provide the Office of Internal Oversight Services with the necessary resources to fulfil its mandate. She asked how the Secretariat planned to address the high number of reports of wrongdoing, especially those relating to fraud, harassment and failure to comply with professional standards.

The DIRECTOR (Office of Internal Oversight Services) said that the Office of Internal Oversight Services always acted independently and objectively in the completion of its work. He attributed the modest improvement in internal controls to the fact that various initiatives were at different stages of maturity and it would take time for all of them to filter through an organization as decentralized as WHO and to be reflected in audit findings. With regard to planning the scope and coverage of its work, the Office of Internal Oversight Services had a robust risk assessment model to prioritize the allocation of resources to the roughly 220 budget centres across the Organization, and to make sure it looked at what it considered to be the most high-risk areas. Also taken into account in planning were problems observed in budget centres that were subsequently covered or in specific thematic areas. There were several mechanisms to make the Office of Internal Oversight Services as innovative as possible in using resources to maximum effect. He did not necessarily regard the increasing number of cases of wrongdoing reported as negative. In order to tackle the backlog of cases, a structured intake process had been implemented: a committee reviewed each allegation at the time it was received to decide on the priority to be given to it; a recommendation was then made to the Director of the Office, who decided the resources to be allocated to the investigation. An additional full-time investigator had been recruited in 2015 and recruitment was under way for three temporary posts and a support staff post. The implementation of audit recommendations was at its highest ever point, but the challenge was how to achieve systemic, sustainable change. Part of the answer lay in integration in the Organization's information technology systems, so that controls became more automated and less dependent on individuals. Supervisory control also had to be enhanced so that, where rules and guidelines were not followed, somebody reviewing the transaction would identify the error or omission and take corrective action. With regard to the Ebola audit, there had been close contact with the people designing the processes and structures under the new WHO Health Emergencies Programme and he was satisfied that they had taken into account the many operational recommendations made.

The ASSISTANT DIRECTOR-GENERAL (General Management) said that the issue of procurement was taken very seriously and the need for improvement had been recognized. A full-time senior staff member had been recruited to lead the work on WHO's procurement policy and strategies and a new strategy, which was implemented separately with respect to goods and services, had been developed. General Management had also been working with the team developing the new WHO Health Emergencies Programme to ensure that it included the right standard operating procedures. The consequences of non-compliance included written reprimand, demotion and consequent reduction in salary, and dismissal, all of which had been implemented in different cases the previous year. Preventive measures had also been introduced, including the dissemination throughout the Organization of information about cases of proven wrongdoing or non-compliance, including the sanctions imposed. Investigation reports were analysed in order to determine how the control system could be improved.

The EXECUTIVE DIRECTOR (Office of the Director-General) said that the question of risk appetite was covered in the corporate risk management policy, which noted that the Organization had a very low risk appetite for administration and finance, but a somewhat higher one in operational work. The task of identifying the risk appetite for each risk in the risk register was expected to be completed within a few months. With regard to the adequacy of the financing of internal controls, three processes were under way: WHO was involved in a process to determine an oversight model for the United Nations system as a whole. One of the first steps in the process was to make sure that all organizations were using the same scope of work in order to define what went into the oversight model, how it was costed and how it could be compared across the different organizations. WHO was also contributing to a study by the Joint Inspection Unit of the United Nations System of internal audit functions in the System. The Independent Expert Oversight Advisory Committee played a key role by reviewing audit plans and advising on the adequacy of investments in internal controls. As for the current financing of the Office of Internal Oversight Services, the expenditure for 2014–2015 was about US\$ 8.4 million, to which were added the costs of the external auditors and the Committee, which together came to about US\$ 1 million, making a total expenditure of about US\$ 9.4 million. The impact of investments also needed to be monitored, for which additional investment would be required.

The Committee noted the report.

The meeting rose at 12:10.

THIRD MEETING

Thursday, 26 May 2016, at 14:40

Chairman: Dr PHUSIT PRAKONGSAI (Thailand)

later: Dr M. KIFLE (Ethiopia)

1. STAFFING MATTERS: Item 22 of the agenda

Human resources: annual report: Item 22.1 of the agenda (documents A69/52 and A69/65)

The representative of the UNITED KINGDOM OF GREAT BRITAIN AND NORTHERN IRELAND, speaking in her capacity as Chairman of the Programme, Budget and Administration Committee of the Executive Board, presented the Committee's report (document A69/65) following its consideration of the annual report on human resources (document A69/52). The Committee, on behalf of the Executive Board, had recommended that the Health Assembly should note the report in document A69/52.

The representative of SEYCHELLES said that the first stage of implementing the geographical mobility policy had been positive: regular reports, qualitative rather than quantitative in nature, would be welcome as the policy became mandatory. The Secretariat's efforts to redress gender inequalities and imbalances in the geographical distribution of both employees and interns were commendable, but more work was required.

The representative of THAILAND said that the staff in the professional grades was still overwhelmingly male. The Secretariat should continue to report regularly about ways to rectify that situation; further work was needed to attain full gender parity as soon as possible. Geographical representation should also be improved. Four regions were significantly overrepresented within the WHO staff, while many countries were still unrepresented or underrepresented. Information on gender balance and geographical representation must be made more publicly available.

The representative of JAPAN said that competent staff were needed at all three levels of the Organization. He commended the setting of numerical targets and the tackling of gender inequality. The setting of numerical targets in terms of international staff members at the regional level, as well as further implementation of the geographical mobility policy, might help to increase the proportion of international professional staff in the regional offices. Japan had been greatly underrepresented for many years; although efforts were being made to equip Japanese citizens with the right skills to work at WHO, further steps from the Secretariat to rectify the situation were urged.

The representative of CHINA said that a managed mobility policy would enhance staff members' skills and career prospects, with better working conditions for staff in less developed regions, support for mobility between and among the different levels of the Organization and more staff employed from unrepresented and underrepresented countries. Restructuring the Secretariat to include a greater proportion of professional and higher-category staff would improve efficiency and specialization. Only a small minority of interns were from developing countries: geographical representation must be improved, for instance through scholarship programmes and increased internship opportunities in the regional offices.

The representative of FRANCE said that the presentation of information on general human resources management and human resources for the crisis response in two different reports made it difficult to get an overall view of the situation. Levels of staff mobility between regions had increased between 2014 and 2015, but very low numbers of headquarters staff members had taken up posts elsewhere. She asked about the non-financial incentives being offered to headquarters staff to move to regional or country offices, and the guarantees given to them about their right to return to headquarters at the end of the posting. There had been only a slight increase in the numbers of permanent staff compared with temporary staff: a rise in the number of staff in precarious work situations should be avoided. She asked for further information about the Secretariat's forward planning for the implementation of United Nations General Assembly resolution 70/244 on the United Nations common system. She also asked how staffing levels were being aligned with new programming priorities, particularly with regard to country-level emergency situations.

The representative of the UNITED STATES OF AMERICA said that, as WHO continued to recruit expert, world-class staff, the most important factor should be to ensure that appointments were made on the basis of competence and skills. She supported the policies in place to improve gender and geographical representation. She requested that reports on the human resources implications of the closure of the Global Polio Eradication Initiative, scheduled for 2019, should be discussed by the governing bodies as a regular agenda item.

The representative of MEXICO said that the geographical mobility policy would enhance the professionalism of the staff and encourage transparency, although continuous follow-up and evaluation of the pilot and subsequent phases would be needed. More should be done in order to achieve the end goal of complete gender parity among the staff. She asked for more information about the new internal justice policy, which must also take into account the changes involved in the WHO reform process. Different situations around the world required different solutions: for example, there was a need for more intensive capacity-building in some areas of the world than others.

The representative of GERMANY said that the mobility policy must be seen as fair and create the right incentives for staff members to move between offices: the incentives in the current policy were not clear. The mobility policy was a major challenge, and there were indications that the Secretariat was not creating the expanded capacity that would be required to deal with the new system. All Member States should be adequately represented in the professional grades: he asked whether data on the nationality of staff members could be disaggregated by regional office. He urged the Secretariat to bring the issue of human resources management in the Global Polio Eradication Initiative to the governing bodies as a regular agenda item, because large numbers of permanent and temporary staff depended on funding from the Initiative.

The representative of AUSTRALIA, noting the progress in implementing the mobility policy, endorsed Germany's call for ensuring appropriate incentives. He commended the review of methods for identifying WHO representatives, as WHO country offices played such a vital role in supporting governments in developing strong health systems. Skill sets relevant to each country office should be sought when staff were recruited. The updated workforce data would be useful in the context of broader WHO reform. Efforts to strengthen the internal justice system and to improve diversity in the WHO internship programme were also to be commended.

The representative of SOUTH AFRICA said that WHO internships were offered on the same terms as internships across the United Nations system, all of which were unpaid. Alternative ways of supporting interns should be considered, particularly in terms of travel and subsistence costs. A mechanism similar to that used for financial support for the least developed countries might be considered.

The representative of the UNITED KINGDOM OF GREAT BRITAIN AND NORTHERN IRELAND said that, although a think tank on gender equity was to be welcomed, more efforts were needed to reach gender parity for higher professional posts at all three levels of the Organization. An increase in the number of female heads of country offices would be a particularly positive development. She welcomed the commitment of the Director of Human Resources to update the reform dashboard and report against all human resources indicators in future reports. That would help the governing bodies to assess progress towards the Organization's reform priorities.

The representative of SWEDEN asked for more information about the efforts to improve gender balance, especially at senior management levels, including targets, indicative timelines and measures taken. She supported the comments of the representative of Germany about the geographical mobility policy.

The DIRECTOR (Human Resources Management) reaffirmed the commitment of middle and senior managers across the Organization to improving gender balance and geographical representation. The Secretariat strongly encouraged applications for vacancies from female candidates and candidates from underrepresented countries, and included explicit wording to that effect in each vacancy notice published online. More highly-qualified candidates might apply if Member States helped to distribute all vacancy notices widely within WHO offices, national ministries and elsewhere. However, the regulatory framework stipulated that gender and nationality could only be taken into account where two equally-qualified candidates were being considered. Efforts were being made to establish a work environment suitable for working mothers and mitigate any unconscious bias against promoting women to higher-level positions. Much had been learned from the first mobility exercise.

Turning to incentives for mobility, she said that WHO staff would apply for positions at the same grade at a different duty station. The staff mobility programme was designed to help staff to enhance their skills and knowledge, and to improve their chances of successfully applying for ad hoc posts. Certain duty stations posed difficulties, and steps were being taken to enhance the mobility policy to allow staff to apply for higher level positions in those duty stations. By 2019, the geographical mobility scheme would be mandatory. When staff members vacated posts to move to another duty station, they had no right of return, and their posts would not be kept open. PAHO was not part of the WHO mobility scheme, but interagency transfers between the two organizations did take place. She did not have human resources data for PAHO.

The mobility policy also provided the Organization with an opportunity to align its staffing structure with its new priorities. Posts vacated by staff members might be cancelled or downgraded, for example. The mobility scheme would help to ensure that the Organization had a versatile and agile workforce.

The internship programme provided opportunities for young people to obtain training and gain specialist knowledge. Internships were unpaid. If interns were to receive subsidies, the necessary funding would first have to be obtained. Measures were also being taken to encourage interns to obtain professional experience in regional or country offices, which would introduce them to the concept of staff mobility.

With regard to the closure of the Global Polio Eradication Initiative, her department would work on the succession planning and transition process with the Global Polio Eradication Initiative team. Her department was also working with the new WHO Health Emergencies Programme to ensure a corporate approach to staffing and training.

The ASSISTANT DIRECTOR-GENERAL (General Management) said that mobility was a top priority, and that the Organization had adopted a corporate approach to that issue and to gender equality, in order to implement recommendations at country, regional and headquarters levels. The General Management Cluster had been working closely with WHO staff associations in that regard. A set of about 30 recommendations, drafted by the gender think tank which had been established for that

purpose, had been endorsed by the Director-General, and a corresponding implementation plan was currently being drafted.

Interns were overrepresented at headquarters, and he would welcome the creation of more internships at regional and country levels. It was estimated that remunerating all WHO interns would cost the Organization US\$ 3 million per year; to minimize such a cost would likely mean significantly reducing the number of interns. The Secretariat would welcome funding from Member States or donors, should that be forthcoming, and could inform interns of scholarship opportunities or other sources of funding. The internship programme should not be viewed as a way of replacing staff members. It provided a learning experience for interns, and involved a significant investment on the part of the Organization, in the form of supervision and mentoring performed by WHO staff members. In spite of those hidden costs, however, it was a worthwhile exercise.

A report on the conclusion of the Global Polio Eradication Initiative and its impact on human resources would be submitted to the Executive Board in January 2017. It would cover separation through natural attrition, separation by mutual agreement, and the funds required to cover liabilities. There was scope to move some of the technical experts from the programme into other programme areas, but it would not be possible to retain all staff members. Regular progress updates would be provided to the governing bodies.

The CHAIRMAN took it that the Committee wished to take note of reports A69/52 and A69/65.

The Committee noted the reports.

Report of the International Civil Service Commission: Item 22.2 of the agenda (document A69/53)

The representative of THAILAND said that his Government had increased the age of separation to 65–70 years in the justice sector, and planned to do the same in other sectors in the near future. He welcomed the report of the International Civil Service Commission, and supported the new mandatory retirement age for staff recruited before 2014, namely 65 years, and the decision on a unified base/floor salary structure. He requested the Secretariat to assess the implications of raising the age of separation, and encouraged it to improve the human resources management structure. In order to ensure that the staff recruitment process was transparent and accountable and that salaries were based on performance.

The DIRECTOR (Human Resources Management) said that United Nations General Assembly resolution 70/244 provided for the revision of the remuneration package for international professional staff. Given that the provisions of the resolution were to be implemented throughout the United Nations common system, the Organization was preparing to make the necessary changes, which included amendments to the Staff Rules and all administrative decisions relating to the calculation of staff entitlements. The draft amendments would be submitted to the Executive Board in 2017. Moreover, steps were being taken to adapt the Global Management System to ensure that the staff payroll system reflected the new salary structure. All relevant changes would be implemented within the time frame set by the General Assembly.

The raising of the mandatory age of separation to 65 years for serving staff, also stipulated in resolution 70/244, required further amendments to the Staff Rules, in order to align them with those of other United Nations common system bodies. The extension of the mandatory age of separation for United Nations staff was not – in contrast to similar changes implemented by many Member States – linked to the sustainability of the United Nations pension system, but was designed to provide staff with the opportunity to continue contributing to the work of the United Nations for an additional 3 years. Staff members would still have the option of retiring earlier, without any negative impact on their pensions.

Raising the mandatory age of separation could delay efforts to improve the gender balance and geographical representation and to rejuvenate the Organization, and have an impact on the alignment of the WHO staffing structure with the Organization's new priorities. The Secretariat would report on those issues to the Board in January 2017.

The Committee noted the report.

Amendments to the Staff Regulations and Staff Rules: Item 22.3 of the agenda (documents A69/54 and EB138/2016/REC/1, resolutions EB138.R10 and EB138.R13)

The representative of THAILAND, referring to resolution EB138.R10, said that remuneration for staff in ungraded posts should be performance-based and take into account the staff member's contribution to the Organization. Referring to resolution EB138.R13, she supported the proposed amendment to the title of Article XI of the Staff Regulations from "Appeals" to "Dispute Resolution" and the recommendation concerning the referral of staff members to the Administrative Tribunal of the ILO, as an alternative to resolving the dispute internally. She supported the draft resolutions.

The CHAIRMAN took it that the Committee wished to take note of report A69/54.

The Committee noted the report.

The CHAIRMAN took it that the Committee wished to approve the draft resolutions recommended in resolutions EB138.R10 and EB138.R13.

The draft resolutions were approved.¹

Appointment of representatives to the WHO Staff Pension Committee: Item 22.4 of the agenda (document A69/55)

The CHAIRMAN drew attention to the proposal to nominate Dr Palitha Gunarathna Mahipala (Sri Lanka) as a member and Dr Naoko Yamamoto (Japan) and Dr Gerardo Lubin Burgos Bernal (Colombia) as alternate members of the WHO Staff Pension Committee, all for a three-year term until May 2019.

The representative of THAILAND supported the proposals.

It was so decided.²

2. MANAGEMENT AND LEGAL MATTERS: Item 23 of the agenda

Real estate: update on the Geneva buildings renovation strategy: Item 23.1 of the agenda (documents A69/56 and EB138/2016/REC/1, resolution EB138.R7)

¹ Transmitted to the Health Assembly in the Committee's second report and adopted as resolutions WHA69.16 and WHA69.17.

² Transmitted to the Health Assembly in the Committee's second report and adopted as decision WHA69(17).

The CHAIRMAN drew attention to the inclusion in the Director-General's report (document A69/56) of a draft decision recommended to the Health Assembly for adoption by the Executive Board in resolution EB138.R7.

The representative of the UNITED KINGDOM OF GREAT BRITAIN AND NORTHERN IRELAND acknowledged the Secretariat's efforts to ensure the cost-effectiveness of the buildings renovation project, particularly in terms of financing, the benefits of the interest-free loan and the long-term energy efficiency of the proposed new building. She strongly welcomed the recognition in the report of the need for a flexible and versatile work space. She concurred with the provision in the draft decision that further authority should be sought from the Health Assembly if the total cost of the project was likely to increase by more than 10%.

The representative of THAILAND said that Member States should be made aware of both the benefits and the risks associated with the buildings renovation project. Such risks must be effectively managed, and in all future projects WHO should include a comprehensive risk register and risk control procedure. She welcomed the establishment of the Member State Advisory Committee, but requested further clarification of its role and composition, as well as its links with other governance bodies involved in the project. She also sought clarification regarding the Organization's right to the buildings and the land on which they were located following expiration of the 100-year building right period in 2065. She expressed support for the draft decision.

The representative of the UNITED STATES OF AMERICA welcomed the flexibility inherent in the design of the new building. She thanked the Secretariat for its efforts to increase efficiencies in materials, construction and renovation costs, noting that the renovation project should be effectively managed to ensure its completion within the amount of approved financing. She reiterated her support for the comprehensive renovation strategy and the associated financing plan and called for regular reports to be provided.

The representative of FRANCE welcomed the fact that long-term reductions in the cost of the buildings renovation project had been identified and that the associated financial risks had been mitigated. She requested clarification as to whether an increase in the budget for the buildings renovation project would be required in order to repay the loan from the Swiss Confederation.

The representative of CHINA thanked the Government of Switzerland for providing the loan to WHO for the construction of the new building. Noting that the buildings renovation strategy was both necessary and feasible, she urged the Committee to approve the draft decision. Given the large scale of the project, she requested that the Executive Board should be provided with a more detailed implementation plan and road map. To ensure transparency, she further requested that the Director-General should report to Member States on the status of the budget for the project.

The representative of CANADA, observing the need to properly scope and effectively manage major projects in order to minimize the risk of negative cost-related and other consequences, noted the concerted efforts of the Secretariat to review the original proposal, which had resulted in a reduction in the cost estimate of the entire renovation project. Continued appropriate management and oversight would ensure that the project was delivered within the approved budget. He expressed appreciation for the openness and accessibility demonstrated by the Secretariat in the context of the renovation strategy and thanked the Swiss authorities for their flexibility and support. He supported the draft decision.

The DIRECTOR (Operational Support and Services) thanked Member States for their input into the buildings renovation process, and expressed appreciation for the collaboration and commitment of the Swiss authorities. He confirmed that a comprehensive risk register would become operational upon

approval of the project and would be shared with the Member State advisory committee. In that connection, he reminded the regional focal points that nominees for the advisory committee should be submitted before the end of the current Health Assembly.

The Organization currently had an indefinite building right on the land on which the buildings were located; however, negotiations were under way to align that right with the provisions of the loan granted by the Swiss authorities, and Member States would be kept informed of the outcome. Currently, the value of any property constructed by WHO on that land would be reimbursed in the event that the Swiss authorities needed to reacquire it. A contingency had been provided for in the approved financing for the strategy; a report on the updated situation would be communicated to Member States in 2018.

The CHAIRMAN invited the Committee to consider the draft decision reproduced in document A69/56.

The draft decision was approved.¹

Process for the election of the Director-General of the World Health Organization: Item 23.2 of the agenda (documents A69/57 and EB138/2016/REC/1, decision EB138(2))

The CHAIRMAN drew attention to document A69/57, which included the text of the draft resolution recommended by the Executive Board in decision EB138(2).

The DIRECTOR-GENERAL recalled that the Health Assembly had decided in resolution WHA66.18 (2013) to establish a candidates' forum to facilitate an exchange between Member States and candidates applying for the post of Director-General, which would be webcast in order to allow those Member States unable to attend the forum to nevertheless watch and listen to the discussion. The post of Director-General was due to be filled in 2017, but since the procedure had been agreed upon, a much greater demand for transparency had emerged in many areas, including the process for the election of the United Nations Secretary-General. Against that background, she asked Member States whether they would be willing to consider webcasting the candidates' forum in November 2016 as well as the statements to be delivered by the three nominated candidates to the Seventieth World Health Assembly. The practice of webcasts for Member States already existed; the issue was whether the public should also be able to listen to, but not intervene in, the statements made by the nominated candidates.

The inability of the Director-General and the Secretariat, under the relevant rules of procedure of the Executive Board, to disclose to the media the candidates for the post of Director-General constituted a source of embarrassment for the Organization. Although under the rules nominations could be disclosed by the Secretariat once the Chairman of the Executive Board had opened all the sealed nominations after the deadline for nominations had expired, in reality Member States frequently disclosed their nominations to the public prior to that time. For that reason, she asked Member States to consider whether, subject to the agreement of nominating countries, the Organization should be permitted to disclose to the public the name and country of the nominated candidates immediately upon receipt of the nomination. In view of the demand for greater transparency, such procedural changes were key to the progress of WHO. If Member States agreed to the changes, the wording of the draft resolution would need to be amended accordingly.

The representative of the UNITED STATES OF AMERICA expressed support for both the draft resolution, including the opportunity for nominated candidates to address the Health Assembly,

¹ Transmitted to the Health Assembly in the Committee's third report and adopted as decision WHA69(18).

and the proposals outlined by the Director-General. She agreed with the proposal to webcast the statements delivered by nominated candidates, both at the candidates' forum in November 2016 and at the Seventieth World Health Assembly, subject to their agreement, and had no objection to the names of the nominated candidates being disclosed to the media upon receipt of their nomination.

The representative of CÔTE D'IVOIRE, speaking on behalf of the Member States of the African Region, said that the amendments to the process for the nomination and election of the Director-General should result in greater transparency and equity, and expressed satisfaction that Member States and nominated candidates would be able to hold direct exchanges at the candidates' forum held before the session of the Executive Board which would be webcast. He welcomed the proposal for the Health Assembly to consider up to three nominations from the Board and was in favour of requiring nominated candidates to address the Health Assembly, thereby enabling those Member States that had been unable to attend the candidates' forum to better familiarize themselves with the candidates. He expressed support for the draft resolution.

The representative of MEXICO expressed support for the Director-General's proposals, which would increase the transparency of WHO.

The representative of CHINA expressed support for the draft resolution and the Director-General's proposals, noting that the innovative election process for the post of Director-General would be more transparent and democratic. The proposal for nominated candidates to address the Health Assembly before the vote would enable Member States to familiarize themselves with the candidates; however, the topics to be discussed by the candidates should be selected by the Executive Board, and candidates should express their views on major governance issues affecting WHO and provide information on any policies that they would implement. She supported the proposal regarding the webcasting of candidates' statements.

The representative of the UNITED KINGDOM OF GREAT BRITAIN AND NORTHERN IRELAND strongly supported the principle of transparency across the Organization and welcomed the proposal to webcast both the candidates' forum and the statements delivered by nominated candidates at the Health Assembly. She had no objection to the Secretariat disclosing the names of candidates, subject to their agreement, but it would be equally acceptable for the Secretariat to reveal the names of candidates only after the deadline for receipt of nominations had passed. The webcasting of candidates' presentations to the public would undoubtedly place them under increased pressure, but given that media attention was a key part of the post of the Director-General, doing so would not be unreasonable.

The representative of the CONGO asked about the procedure preceding the official disclosure of the candidates' names and the candidates' forum.

The representative of COSTA RICA expressed support for the draft resolution.

The representative of PANAMA expressed support for the draft resolution and for the proposal to webcast candidates' presentations and the candidates' forum in November 2016. He supported the disclosure of candidates' names immediately upon their receipt by the Secretariat, and the disclosure of any subsequently withdrawal of a candidacy.

The representative of the PHILIPPINES noted the importance of transparency and the benefit of enabling Member States to familiarize themselves with nominated candidates. She concurred with the proposal to disclose the names of candidates to the media upon their receipt by the Secretariat.

The representative of THAILAND welcomed the improvements to the process for the election of the post of Director-General and endorsed the recommendation that nominated candidates should be required to address the Health Assembly.

The representative of CANADA strongly supported the proposals that had been made with the aim of enhancing the transparency of the election process and approved the recommendation to webcast candidates' presentations. It would be preferable for the Secretariat to state that it would be in a position to disclose the names of candidates only after the deadline for the receipt of nominations had passed; however, subject to the agreement of the nominating Member States, it would be acceptable for it to indicate that it was aware of a public announcement by a Member State that it had nominated a candidate.

The LEGAL COUNSEL said that the names of candidates would be formally announced on 23 September 2016 when the nominations were unsealed. If the Committee wished to allow nominations to be made known before that date, he envisaged that the Director-General would, upon receiving a sealed nomination from a Member State, contact the Member State via the Secretariat to enquire whether it wished the fact that it had made a nomination, and the name of the individual nominated, to be made public. If the Member State so agreed, a statement would be published on the official WHO website indicating that the Director-General had received a nomination from the government in question, and naming the individual. At such a time, the candidacy would be prospective only; formal recognition of the candidacy would occur only when the nominations were opened. However, the possibility of publishing the nominations would avoid the potential embarrassment of the Director-General being the only person not allowed to name the announced candidates.

With regard to the webcasting of statements at the Seventieth World Health Assembly, he proposed amending the draft resolution contained in document A69/57 by addition of a subparagraph (d) to the operative paragraph, which would read as follows: "statements shall be webcast on the WHO website in all official languages".

It would be sufficient, if consensus were reached, for the Committee's decisions regarding the announcement of nominations and the webcasting of the candidates' forum to be recorded in the summary record of the meeting.

Replying to a question from the representative of MALTA, he said that there was no need to amend the existing rules of procedure of the World Health Assembly or the Executive Board.

The representative of THAILAND supported the Legal Counsel's proposal.

The CHAIRMAN took it that the Committee noted with approval the Director-General's intention to acknowledge the names of prospective candidates for the position of Director-General before the deadline for submitting candidatures had expired, if the nominating State so agreed. He also took it that the Committee agreed to the proposal that the candidates' forum established by resolution WHA66.18 (2013) be webcast on the WHO website in all official languages. Lastly, he took it that the Committee agreed to the proposal to webcast the statements of the nominated candidates to the Seventieth World Health Assembly on the WHO website in all official languages. To that end, he invited the Committee to approve the draft resolution contained in document A69/57, with the addition of a new subparagraph (d) in the operative paragraph, reading as follows: "(d) statements shall be webcast on the WHO website in all official languages".

The draft resolution, as amended, was approved.¹

3. COLLABORATION WITHIN THE UNITED NATIONS SYSTEM AND WITH OTHER INTERGOVERNMENTAL ORGANIZATIONS: Item 24 of the agenda (document A69/58)

The representative of MALAWI, speaking on behalf of the Member States of the African Region, said that WHO had made progress in strengthening United Nations support for Member States for the purpose of implementing the 2030 Agenda for Sustainable Development. The forthcoming resolution on the quadrennial comprehensive policy review, announced by the United Nations General Assembly in 2012, had the potential to provide a valuable framework for such support, especially at country level. The dialogue initiated by the Member States of the United Nations Economic and Social Council should continue to focus on the seven interlinked components: functions, funding, governance, organizational arrangements, capacity, impact and partnership approaches. It was important to ensure that all organizations within the United Nations system made progress in parallel. A dialogue with Member States on an appropriate funding model, accompanied by a transparent reporting system on the use of resources, should take place in order to facilitate the required increase in core resources. WHO should continue to strengthen its internal capacity to be a strong member of United Nations country teams in all regions.

The representative of MEXICO said that the 2030 Agenda for Sustainable Development and the Addis Ababa Action Agenda of the Third International Conference on Financing for Development placed particular emphasis on the agencies, funds and programmes of the United Nations system working together in a more relevant, coherent, efficient and effective manner. He called on the Secretariat to reinforce its role as a leader in global health for the achievement of the public health aspects of the 2030 Agenda. He invited the Director-General to participate actively in the discussions on the follow-up to and implementation of the 2030 Agenda at the upcoming Economic and Social Council High-level political forum on sustainable development and to report on the results of her participation to the Executive Board at its 140th session.

The representative of THAILAND welcomed efforts to implement coherent coordination mechanisms within the United Nations system and among other intergovernmental organizations for the implementation of the Sustainable Development Goals. She fully supported the integrated mind-set that the United Nations family was striving to achieve, but the vertical structure of each organization posed great challenges. Strong leadership on the part of the United Nations Secretary-General would be essential for an integrated approach. As part of the reform process currently underway, WHO should adjust its work to better contribute to the United Nations Development Assistance Framework. The Secretariat should submit progress reports to the Health Assembly every three years on the way collaboration within the United Nations system was helping Member States to implement the Sustainable Development Goals.

The representative of the UNITED STATES OF AMERICA noted WHO's initiatives, such as the financing dialogue, which were consistent with the efforts to achieve greater coherence within the United Nations system and support country efforts to implement the 2030 Agenda. Thanks to WHO's commitment to participating in joint efforts such as "Delivering as One" and initiatives to develop shared and common services, opportunities to identify efficiencies and promote streamlining were opening up. Another area in which WHO had fostered greater harmonization was the strengthening of

¹ Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA69.18.

the role of the health sector in addressing violence against women. She commended WHO's advancement of a life-course approach to violence against women and children, which had guided regional strategies and complemented the treatment of gender violence advanced by the post-2015 development agenda.

The representative of the REPUBLIC OF KOREA said that the inclusion of country cases in the report made it easier to understand how all levels of WHO worked together with United Nations organizations in various ways. Continued collaboration would be necessary to achieve the Sustainable Development Goals, which emphasized multisectoral and cross-cutting approaches. The importance of the WHO financing dialogue in improving the alignment, flexibility, predictability and transparency of major resources was much appreciated. However, progress on WHO reform had been slow. WHO reform should be accelerated in the interests of sustainable development.

The representative of AUSTRALIA said that WHO's continuing work to implement the quadrennial comprehensive policy review recommendations were a practical measure which would improve coordination with other United Nations agencies. He appreciated WHO's successful coordination of United Nations input to the Healthy Islands indicators in the Pacific region.

The EXECUTIVE DIRECTOR (Office of the Director-General) said that Member States' comments on specific aspects of the quadrennial comprehensive policy review process were helpful; there would be a strong focus on engagement at the global and country levels and on pursuing the United Nations General Assembly's "Delivering as One" approach. He confirmed that the Secretariat would report regularly to the governing bodies on its engagement with the United Nations system with regard to the 2030 Agenda. The next report, to be submitted to the Seventieth World Health Assembly, would show how the 2030 Agenda was being advanced in the collaboration between WHO and the United Nations system.

The Committee noted the report.

Dr Kifle took the Chair.

4. HEALTH SYSTEMS: Item 16 of the agenda [transferred from Committee A]¹

Health workforce and services: Item 16.1 of the agenda (documents A69/36 and A69/37)

- **Draft global strategy on human resources for health: workforce 2030** (document A69/38)
- **Framework on integrated, people-centred health services** (documents A69/39 and EB138/2016/REC/1, resolution EB138.R2)

The CHAIRMAN drew attention to the documents relevant to the subitem and to a draft resolution on the draft global strategy on human resources for health: workforce 2030, proposed by the delegations of Argentina, Japan, Mozambique, Norway, South Africa, Switzerland, Thailand, the United States of America, Zambia, Zimbabwe and the Member States of the European Union, which read as follows:

¹ See summary record of the General Committee, first meeting, section 2.

The Sixty-ninth World Health Assembly,

PP1 Having considered the report on the draft global strategy on human resources for health: workforce 2030;¹

PP2 Reaffirming the continuing importance of the application of the WHO Global Code of Practice on the International Recruitment of Health Personnel (hereinafter “WHO Global Code”);²

PP3 Recalling previous Health Assembly resolutions aimed at strengthening the health workforce;³

PP4 Recalling also the United Nations General Assembly resolutions in 2014 and 2015 that, respectively: call on Member States, in cooperation, as appropriate, with relevant international organizations and relevant non-State actors, to develop effective preventive measures to enhance and promote the safety and protection of medical and health personnel, as well as respect for their respective professional codes of ethics;⁴ and underline the importance of adequate country capacity to respond to public health threats through strong and resilient health systems, benefiting from the availability of motivated, well trained and appropriately equipped health workers;⁵

PP5 Inspired by the ambition of the 2030 Agenda for Sustainable Development, including its strong multisectoral dimension and call to achieve universal health coverage;

PP6 Guided by the call in Sustainable Development Goal 3, Target 3.c to “substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing States”;

PP7 Recognizing that health workers are integral to building strong and resilient health systems that contribute to the achievement of the Sustainable Development Goals and targets related to nutrition, health, education, gender, employment, and the reduction of inequalities;⁶

PP8 Recognizing further that Sustainable Development Goal 3 (“Ensure healthy lives and promote well-being for all at all ages”) and its targets will only be attained through substantive and strategic investments in the global health workforce, as well as a substantial shift in health workforce-related planning, education, deployment, retention, management and remuneration;

PP9 Recognizing that the domestic health workforce is the primary responder in all countries, including those with fragile health systems, and is key to building resilient health systems;⁷

¹ Document A69/38.

² Adopted in resolution WHA63.16 (2010).

³ Resolutions WHA64.6 (2011) on health workforce strengthening, WHA64.7 (2011) on strengthening nursing and midwifery, WHA65.20 (2012) on WHO’s response, and role as the health cluster lead, in meeting the growing demands of health in humanitarian emergencies, WHA66.23 (2013) on transforming health workforce education in support of universal health coverage, WHA67.19 (2014) on strengthening of palliative care as a component of comprehensive care throughout the life course, WHA67.24 (2014) on follow-up of the Recife Political Declaration on Human Resources for Health: renewed commitments towards universal health coverage, and WHA68.15 (2015) on strengthening emergency and essential surgical care and anaesthesia as a component of universal health coverage.

⁴ United Nations General Assembly resolution 69/132 (2014) on global health and foreign policy.

⁵ United Nations General Assembly resolution 70/183 (2015) on global health and foreign policy: strengthening the management of international health crises.

⁶ See Sustainable Development goals and targets at <https://sustainabledevelopment.un.org/?menu=1300> (accessed 25 January 2016).

⁷ See resolution WHA64.10 (2011) on strengthening national health emergency and disaster management capacities and resilience of health systems, and document A68/27 on global health emergency workforce.

PP10 Taking note of the significant infrastructure, assets and human resources of the global polio eradication initiative, and the ongoing legacy process across countries, as appropriate;

PP11 Deeply concerned by the rising global health workforce deficit and the mismatch between the supply, demand and population needs for health workers, now and in the future, which are major barriers to achieving universal health coverage as committed to in Sustainable Development Goal 3, Target 3.8;

PP12 Taking note of the renewed focus on health system strengthening and the need to mobilize and effectively manage domestic, international and other forms of health financing in support of such strengthening;¹

PP13 Encouraged by the emerging political consensus on the contribution of health workers to improved health outcomes, to economic growth, to implementation of the International Health Regulations (2005) and to global health security;

PP14 Recognizing that investing in new health workforce employment opportunities may also add broader socioeconomic value to the economy and contribute to the implementation of the Sustainable Development Goals,

(OP1) ADOPTS the Global Strategy on Human Resources for Health: Workforce 2030 (hereinafter “Global Strategy”), including: its vision of accelerating progress towards universal health coverage and the Sustainable Development Goals by ensuring universal access to health workers; its principles; its four strategic objectives; and its milestones for 2020 and 2030;

(OP2) URGES all Member States,^{2,3} as integral to health systems strengthening:

- (1) to adapt the Global Strategy’s four strategic objectives within national health, education and employment strategies, and to broader socioeconomic development contexts, in line with national priorities and specificities;
- (2) to engage relevant sectors and ensure intersectoral mechanisms at the national and subnational levels as required for efficient investment in and effective implementation of health workforce policies;
- (3) to implement policy options as proposed for Member States by the Global Strategy, supported by high-level commitment and adequate financing, including through the implementation of the WHO Global Code, in particular towards:
 - (a) strengthening capacities to optimize the existing health workforce to enable it to contribute to the achievement of universal health coverage;
 - (b) actively forecasting and closing gaps between health workforce needs, demands, and supply, including by geographical distribution, as well as the gaps in the distribution of health workforce between public and private sectors, and through intersectoral collaboration;
 - (c) building the institutional capacity at the subnational and national levels for effective governance and leadership of human resources for health, which will form, for example, an essential component in the building of comprehensive

¹ See, for example, the “Healthy Systems – Healthy Lives” initiative, and resolutions WHA64.9 (2011) on sustainable health financing structures and universal coverage, WHA62.12 (2009) on primary health care, including health system strengthening, WHA64.8 (2011) on strengthening national policy dialogue to build more robust health policies, strategies and plans, and WHA62.13 (2009) on traditional medicine.

² And, where applicable, regional economic integration organizations.

³ Taking into account the context of federated States where health is a shared responsibility between national and subnational authorities.

national health systems to provide a long-term solution to managing disease outbreaks in their initial phases;

(d) consolidating a core set of human resources for health data with annual reporting to the Global Health Observatory, as well as progressive implementation of national health workforce accounts, to support national policy and planning and the Global Strategy's monitoring and accountability framework;

(OP3) INVITES international, regional, national and local partners and stakeholders from within the health sector and beyond to engage in, and support, the implementation of the Global Strategy and achieve its milestones for 2020 and 2030, in alignment with national institutional mechanisms in order to coordinate an intersectoral health workforce agenda, specifically calling for:

(1) educational institutions to adapt their institutional set-up and modalities of instruction so that they are aligned with national accreditation systems and population health needs; to train health workers in sufficient quantity, quality and with relevant skills, while also promoting gender equality in admissions and teaching; and to maintain quality and enhance performance through continuing professional development programmes, including faculty members and the existing health workforce;

(2) professional councils, associations, and regulatory bodies to adopt regulations to optimize workforce competencies, and to support interprofessional collaboration for a skills mix responsive to population needs;

(3) the International Monetary Fund, the World Bank, regional development banks and other financing and lending institutions to adapt their macroeconomic policies and investment criteria in the light of mounting evidence that investments in health workforce planning, and the training, development, recruitment, and retention of health workers, are conducive to economic and social development and achievement of the Sustainable Development Goals;

(4) development partners, including bilateral partners and multilateral aid mechanisms, to augment, coordinate and align their investments in education, employment, health, gender, and labour in support of domestic financing aimed at addressing national health workforce priorities;

(5) global health initiatives to ensure that all grants include an assessment of health workforce implications, leverage national coordination and leadership, and contribute to efficient investment in and effective implementation of national health workforce policies;

(OP4) REQUESTS the Director-General:

(1) to provide support to Member States, upon request, on the implementation and monitoring of the Global Strategy, including to:

(a) strengthen and optimize their existing health workforces and to anticipate and respond to future health workforce needs;

(b) strengthen governance and leadership of human resources for health, through the development of normative guidance, through the provision of technical cooperation, and through the fostering of effective transnational coordination, alignment and accountability;

(c) develop and maintain a framework for health workforce information systems, including the consolidation of a core set of health workforce data with annual reporting to the Global Health Observatory, as well as the progressive implementation of national health workforce accounts, in order to strengthen the availability, quality, and completeness of health workforce data;

- (d) strengthen implementation of previous Health Assembly resolutions related to the health workforce, including WHA66.23 on transforming health workforce education in support of universal health coverage, the retention of the health workforce, and support Member States upon request;
- (2) to develop capacity to assist Member States, including through the promotion of research, and, upon request, and through technical cooperation and other means, to develop appropriate preventive measures to enhance and promote the safety and protection of medical and health personnel, their means of transport and installations, to improve the resilience of health systems and to promote the effective implementation of universal health coverage;
- (3) to include an assessment of the health workforce implications of technical resolutions brought before the Health Assembly and the WHO regional committees;
- (4) to facilitate the exchange of information and good practice on human resources for health and collaboration among Member States and relevant stakeholders, continuing the practices outlined in the WHO Global Code;
- (5) to submit a regular report to the Health Assembly, through the Executive Board, on progress made towards the milestones established by the Global Strategy, aligned with reporting on the WHO Global Code.

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

Resolution: Draft global strategy on human resources for health: workforce 2030	
A.	Link to the general programme of work and the programme budget
1.	<p>Please indicate to which impact and outcome in the Twelfth General Programme of Work, 2014–2019 and which output in the Programme budget 2016–2017 this draft resolution will contribute if adopted.</p> <p>Twelfth General Programme of Work: Category 4 Health Systems; programme area 4.2 Integrated people-centred health services. Programme budget: Output 4.2.2.</p>
2.	<p>If there is no link to the results as indicated in the Twelfth General Programme of Work, 2014–2019 and the Programme budget 2016–2017, please provide a justification for giving consideration to the draft resolution.</p> <p>Not applicable.</p>
3.	<p>What is the proposed timeline for implementation of this resolution?</p> <p>The proposed implementation timeline spans the 15 years from 2016 to 2030. However, the current financing request is aligned with two bienniums of the Twelfth General Programme of Work, 2016–2017 and 2018–2019.</p> <p><i>If the timeline stretches to future programme budgets, please ensure that further information is provided in the costing section.</i></p>

B. Budgetary implications of implementation of the resolution			
1. Current biennium: estimated budgetary requirements, in US\$ million			
Level	Staff	Activities	Total
Country offices	7.66	13.15	20.81
Regional offices	7.19	1.89	9.08
Headquarters	7.81	3.27	11.08
Total	22.66	18.31	40.97
1(a) Is the estimated budget requirement in respect of implementation of the resolution fully included within the current programme budget? (Yes/No)			
Yes.			
1(b) Financing implications for the budget in the current biennium:			
– How much is financed in the current biennium?			
US\$ 17.00 million			
– What are the gaps?			
US\$ 23.97 million			
– What action is proposed to close these gaps?			
The gap will be addressed through coordinated resource mobilization efforts for possible financing by voluntary contributions.			
2. Next biennium: estimated budgetary requirements, in US\$ million			
Level	Staff	Activities	Total
Country offices	8.04	13.81	21.85
Regional offices	7.55	1.99	9.54
Headquarters	8.19	3.43	11.62
Total	23.78	19.23	43.01
2(a) Financing implications for the budget in the next biennium:			
– How much is currently financed in the next biennium?			
0			
– What are the financing gaps?			
US\$ 43.01 million			
– What action is proposed to close these gaps?			
The gap will be addressed through coordinated resource mobilization efforts, including the financing dialogue, for possible financing by voluntary contributions.			

The representative of MALDIVES outlined the challenges faced by her country, which had a geographically dispersed population and no medical school. Meeting the demand for health-care professionals was problematic; in order to optimize recruitment, training, staff retention and resource distribution, a human resources plan and a new salary structure had been introduced. WHO's support remained essential.

The representative of ESTONIA, speaking on behalf of the Nordic and Baltic countries Denmark, Estonia, Finland, Iceland, Latvia, Lithuania, Norway and Sweden, said that putting patients first and providing increased integration was one way to ease the increasing strain on health services, and should be a priority for all stakeholders. At its next session in September 2016, the Regional Committee for Europe would consider a draft framework for action towards coordinated/integrated health services delivery. Some of the biggest challenges lay in including the social sector and reaching out to communities. Regional adaptations should be made to the framework on integrated people-centred health services, and special attention should be paid to the starting point of low-income countries, where qualified personnel and health services were most scarce. He encouraged WHO to work with the broad science community and with OECD to develop indicators to measure progress without imposing too heavy a reporting burden on Member States.

The representative of SIERRA LEONE, speaking on behalf of the Member States of the African Region, said that health sector reforms must promote all aspects of staff development and retention, including recruitment, training, deployment and the establishment of good working and living conditions. Health financing should be increased and good staff performance rewarded. Continental or subregional norms and standards of training and licensing should be established, and countries should explore the opportunities for partnerships between the private and public sectors to ensure the optimal use of resources. All countries should establish national health workforce observatories and mechanisms to enhance cooperation, and information exchange among countries should be encouraged. Additionally, a continental mechanism should be established to regulate migration of health workers both within the continent and outside it.

The representative of INDONESIA welcomed the reported vision of accelerating the achievement of universal health coverage and the Sustainable Development Goals by expanding the health workforce and thus access to health-care services. She outlined measures that her Government was taking to increase and enhance the capacities of the health workforce and expressed her support for WHO's efforts to strengthen the health workforce by 2030.

The representative of CHILE, speaking on behalf of the Member States of the Region of the Americas, said that achieving universal health coverage and access to services was a top priority in the Region and listed some important strategies and policies that had been developed to strengthen health-care systems at the national, regional and global levels. Combating the fragmentation and segmentation of health systems and advancing the delivery of more equitable and more comprehensive health-care services was a key aim of the Health Agenda for the Americas 2008–2017.

Inequalities in access to health care and the absence of high-quality health care in some areas were linked to a shortage of skilled health workers, which should be remedied by the coordination of an intersectoral health workforce agenda. The management of human resources for health should be strengthened in order to mitigate the adverse effects of unequal geographical distribution and lack of mobility of health workers. She supported the draft global strategy on human resources for health, which provided a clear opportunity to work towards the Sustainable Development Goals, particularly the recruitment, retention and training of the health workforce.

The representative of SOUTH AFRICA said that the adoption of the draft global strategy on human resources for health: workforce 2030 would be essential to the achievement of Sustainable Development Goal 3. Her Government had taken numerous steps to train and retain health professionals and implement the WHO Global Code of Practice on the International Recruitment of Health Personnel at national level. South Africa was a member of the High-Level Commission on Health Employment and Economic Growth, established by the United Nations Secretary-General in March 2016 to create health and social sector jobs for inclusive growth. She fully supported the

consultative process undertaken to draft and finalize the framework and expressed her support for the draft global strategy and the framework on integrated, people-centred health services.

The representative of the PHILIPPINES endorsed the draft global strategy, particularly its focus on low- and middle-income countries and their limited ability to retain their national health workforces. The strategy offered WHO a unique opportunity to better address the growing economic disparities between countries, increasingly mobile populations and the greater diversity of population-based health needs, which directly affected the supply of health-care workers. As a global source country for health professionals, her Government recognized the value of the WHO Global Code of Practice on the International Recruitment of Health Personnel as a means of increasing investment in human resource development and management. It was heartening that more than eight out of the 10 recipient countries had engaged in the second round of reporting on their implementation of the Code, but WHO should further consider the effectiveness of the national reporting instrument and its applicability to source countries.

The representative of the UNITED KINGDOM OF GREAT BRITAIN AND NORTHERN IRELAND, welcoming the framework on integrated, people-centred health services, said that her country fully supported the draft resolution recommended by the Executive Board in resolution EB138.R2. Her Government remained committed to the implementation of the WHO Global Code and recognized the need for accurate reporting data to improve workforce planning and capacity. She therefore called for a technical review of the established criteria for identifying critical shortages in order to strengthen the bilateral, regional and multilateral agreements designed to enforce the Code. Such a step would enable WHO to respond more effectively to the particular challenges facing individual countries in the recruitment and retention of health personnel.

The representative of SWAZILAND, noting the global health workforce deficit and the mismatch between the supply of and demand for health workers, said that coordinated action and resource sharing between health professionals, policy-makers, governments, nongovernmental organizations, donor agencies and other relevant stakeholders would be required in order to deliver effective health interventions. Member States must pay careful attention to the management and deployment of their respective domestic health workforces and adopt innovative financing mechanisms to make use of private financing sources for the training and retention of health professionals. It was imperative that training activities should be linked to the demands of the national health system in order to deliver the best standard of health care. Development partners should also provide financial assistance for training schemes for health professionals in order to meet the demands of the local population. WHO should continue to focus on strengthening midwifery services and providing guidance and technical assistance on country-specific human resource needs, where necessary.

The representative of SWITZERLAND welcomed the draft global strategy. In order to tackle the lack of qualified personnel, her Government had recently increased the number of training places for doctors and had made additional support and resources available to health-care workers. She welcomed the outcome of the second round of reporting on the WHO Global Code, calling for further progress to be made in the implementation of that instrument.

The representative of GERMANY expressed support for the draft global strategy. Strong health workforces not only helped to build more robust health systems, they also contributed to economic development. Her country, like many others, had been affected by a demographic shift towards an ageing population and had availed itself of the opportunity to create jobs in the social care sector. The WHO Global Code had helped to promote sustainable recruitment, particularly for countries affected by the “brain drain” phenomenon: WHO should therefore continue its efforts to promote the

implementation of the Global Code, especially in South-East Asia. The key role played by women in health care should not be forgotten.

The representative of ZIMBABWE fully supported the draft global strategy; an increasingly interconnected world faced with diverse health challenges required a skilled and well-resourced health workforce. Adequate remuneration, promotion and protection of health professionals would also play an essential role in the achievement of the 2030 Agenda for Sustainable Development. In that connection, she called for additional support to be made available for the implementation of the WHO Global Code.

The representative of AUSTRIA, welcoming the framework on integrated, people-centred health services and the associated draft resolution, said that the empowerment of individuals and communities in their dealings with health services was imperative for better clinical outcomes and universal access to quality services. Measures should therefore be adopted at the national, regional and international levels to strengthen the health literacy of the general public, health-care organizations and health systems with the aim of making health care more accessible to all.

The representative of CANADA expressed support for the efforts made to strengthen the health workforce, particularly in the nursing and midwifery sectors, and to promote the principle of universal health coverage in the training of health personnel. He welcomed the outcome of the second round of reporting on the WHO Global Code of Practice and the improvements witnessed in both the quantity and quality of information received from national authorities and reporting instruments. The lessons learned from each reporting round should be used to target future actions more effectively.

He fully supported the vision and objectives of the draft global strategy on human resources for health, and agreed with the challenges identified in the health-care sector. As for the framework on integrated, people-centred health services, he emphasized the importance of creating links between the social sector and public health activities aimed at underserved and vulnerable populations in order to support the much-needed shift towards community-based care. His Government endorsed the reporting indicators contained in the framework, but reporting on the indicators would be a challenge for Canada as the Federal Government did not have sole jurisdiction over the collection of health-care delivery indicators.

The representative of JAMAICA said that her country, like many other members of the Caribbean Community, had faced challenges, including aggressive recruitment from abroad, in addressing the shortage of specialist health personnel and continued to struggle with the implementation of the WHO Global Code owing to the lack of a designated national or regional reporting authority. She therefore urged the Secretariat to provide support to Caribbean countries in their establishment of appropriate legal frameworks for the implementation of the Global Code and drafting of strategies to improve training and retention of staff so that the countries concerned could fully benefit from the considerable investment in their respective health workforces.

The representative of BELGIUM said that indicators for tracking progress and measuring the level of integration of health services would be crucial to assessing the progress made towards achieving Sustainable Development Goal 3, and asked for clarification of WHO's role in the global efforts to achieve universal health coverage by 2030, particularly in respect of financial and technical assistance. Steps must be taken to reconsider the profile of and training provided for future health-care workers in order to ensure that changing health-care needs were met. He supported the two draft resolutions.

The representative of the REPUBLIC OF MOLDOVA, noting the vital role played by the health workforce in translating public health policies into effective health services, said that her Government

had prioritized the strengthening of human resources for health in its national public health policies, for instance through the introduction of a national information system to monitor the mobility of health professionals. It fully supported the draft global strategy on human resources for health and wished to be added to the list of sponsors of the draft resolution.

(For continuation of the discussion and approval of the draft resolution on the global strategy on human resources for health, see the summary record of the fourth meeting, section 2.)

The meeting rose at 17:30.

FOURTH MEETING

Friday, 27 May 2016, at 10:20

Chairman: Dr M. KIFLE (Ethiopia)

1. SECOND REPORT OF COMMITTEE B (document A69/71)

The RAPPORTEUR read out the draft second report of Committee B.

The report was adopted.¹

2. HEALTH SYSTEMS: Item 16 of the agenda (continued) [transferred from Committee A]²

Health workforce and services: Item 16.1 of the agenda (documents A69/36, A69/37 and A69/37 Add. 1) (continued from the third meeting, section 4)

- **Draft global strategy on human resources for health: workforce 2030** (document A69/38) (continued from the third meeting, section 4)
- **Framework on integrated, people-centred health services** (documents A69/39 and EB138/2016/REC/1, resolution EB138.R2) (continued from the third meeting, section 4)

The CHAIRMAN drew attention to a revised draft resolution on strengthening integrated, people-centred health services, incorporating amendments proposed during informal consultations by the delegations of India, Liberia, Zimbabwe and the Member States of the European Union, which read:

The Sixty-ninth World Health Assembly,

PP1 Acknowledging Sustainable Development Goal 3 (Ensure healthy lives and promote well-being for all at all ages) including target 3.8, which addresses achieving universal health coverage, including financial risk protection, access to quality essential health-care services, and access to safe, effective, quality and affordable essential medicines and vaccines for all;

PP2 Recalling resolution WHA64.9 (2011) on sustainable health financing structures and universal coverage, which urged Member States to continue investing in and strengthening health-delivery systems, in particular primary health care and services, and adequate human resources for health and health information systems, in order to ensure that all citizens have equitable access to health care and services;

PP3 Reaffirming resolution WHA62.12 (2009) on primary health care, including health system strengthening, which requested the Director-General to prepare implementation plans for

¹ See page 384.

² See summary record of the General Committee, first meeting, section 2.

four broad policy directions, including putting people at the centre of service delivery **and also reaffirming the need to continue to prioritize progress on the implementation plans on the other three broad policy directions included in resolution WHA62.12 (2009): (1) dealing with inequalities by moving towards universal coverage; (2) multisectoral action and health in all policies; and (3) inclusive leadership and effective governors for health;**

PP4 Recalling resolution WHA63.16 (2010) on the WHO Global Code of Practice on the International Recruitment of Health Personnel and its recognition that an adequate and accessible health workforce is fundamental to an integrated and effective health system and for the provision of health services;

PP5 Recalling also resolution WHA64.7 (2011) on strengthening nursing and midwifery which emphasize the implementation of strategies for enhancement of interprofessional education and collaborative practice as part of people-centred care, and WHA66.23 (2013) on transforming health workforce education in support of universal health coverage;

PP6 Reaffirming resolution WHA60.27 (2007) on strengthening health information systems, which acknowledged that sound information is critical in framing evidence-based health policy and making decisions, and fundamental for monitoring progress towards internationally agreed health-related development goals;

PP7 Recalling resolutions WHA67.20 (2014) on regulatory system strengthening for medical products, WHA67.21 (2014) on access to biotherapeutic products, including similar biotherapeutic products, and ensuring their quality, safety and efficacy, WHA67.22 (2014) on access to essential medicines, ~~and~~ WHA67.23 (2014) on health intervention and technology assessment in support of universal health coverage **and WHA67.18 (2014) on traditional medicine,**

(OP1) ADOPTS the framework on integrated, people-centred health services;

(OP2) URGES Member States:

(1) to implement, as appropriate, the framework on integrated, people-centred health services at regional and country level, in accordance with national contexts and priorities;

~~(1)~~**(2) to implement proposed policy options and interventions for Member States in the framework on integrated, people-centred health services in accordance with nationally set priorities towards achieving and sustaining universal health coverage, including with regard to primary health care as part of health system strengthening;**

~~(2)~~**(3) to make health care systems more responsive to people's needs, while recognizing their rights and responsibilities with regard to their own health, and engage stakeholders in policy development and implementation;**

~~(3)~~**(4) to promote coordination of health services within the health sector and intersectoral collaboration in order to address the broader social determinants of health and to ensure a holistic approach to services, including health promotion, disease prevention, diagnosis, treatment, disease-management, rehabilitation and palliative care services;**

(5) to integrate where appropriate traditional and complementary medicine and modern health systems, based on national context and knowledge-based policies, while assuring the safety, quality and effectiveness of health services and taking into account a holistic approach to health;

(OP3) INVITES international, regional and national partners to take note of the framework on integrated, people-centred health services;

(OP4) REQUESTS the Director-General:

- (1) to provide technical support and guidance to Member States for the implementation, national adaptation and operationalization of the framework on integrated, people-centred health services, **paying special attention to primary health services as part of health system strengthening;**
- (2) to ensure that all relevant parts of the Organization, at headquarters, regional and country levels, are aligned, actively engaged and coordinated in promoting and implementing the framework on integrated, people-centred health services;
- (3) to perform research and development on indicators to trace global progress on integrated people-centred health services;
- (4) to report on progress **on the implementation of** ~~made in implementing~~ the framework on integrated people-centred health services to the Seventy-first and Seventy-third World Health Assemblies and at regular intervals thereafter.

The financial and administrative implications for the Secretariat of the adoption of the resolution were the same as for resolution EB138.R2 adopted by the Board.¹

The representative of FRANCE, acknowledging WHO's central role in strengthening the global health workforce, said that her country would be increasing its financial support for WHO's human resources department to US\$ 1.2 million in 2016. Not only did health-sector jobs improve people's health, they also stimulated inclusive economic growth and the creation of decent work. She thanked the Director-General for attending the first meeting of the High-Level Commission on Health Employment and Economic Growth (Lyon, France, 23 March 2016), whose work, it was to be hoped, would be widely taken up by other actors. Her Government would also provide support during an upcoming meeting of the francophone countries of OECD on related work. She supported the adoption of the draft global strategy on human resources for health.

The representative of SLOVAKIA said that legislation in her country overlapped with the draft strategy. However, like the WHO Global Code of Practice on the International Recruitment of Health Personnel and other policies, the focus in the draft strategy was on aspects that could be detrimental to source countries like Slovakia. It was important to cooperate to decide how to manage the health workforce in an international context, how changing mobility trends would be accounted for, and what quality data were available for planning. Member States' policies must be aimed at ensuring self-sufficiency and all cooperation should be mutually beneficial. WHO's technical support was essential in implementing the draft strategy. The Slovak Ministry of Health supported the framework on integrated, people-centred health services contained in document A69/39 and had launched several projects in that area, which included establishing "integrated care centres" in regions with insufficient access to care.

The representative of NORWAY noted that attaining target 3.c of the Sustainable Development Goals would help achieve the other targets under Goal 3 and advance the broader sustainable development agenda. Member States and the Secretariat must collaborate in order to meet the goal of universal health coverage and the health-related Sustainable Development Goals. She noted with satisfaction that the draft strategy incorporated commitments from United Nations General Assembly resolution 69/132 on the protection of health workers. Partnerships, global initiatives and a multisectoral approach would be critical to implementing national policies. It was encouraging that reporting on the WHO Global Code had gained momentum.

¹ See document WHA69/2016/REC/1, Annex 15.

The representative of THAILAND said that the Secretariat's update on the status of the global health workforce (document A69/36) failed to provide the clear conclusions and recommendations requested in resolution WHA66.23 (2013). Training for an adequate number of health workers and their equitable geographical distribution, with migration appropriately managed through the WHO Global Code, was of particular concern, along with the recognition of the important role played by front-line providers in achieving the Sustainable Development Goals. She urged the Secretariat to implement resolution WHA66.23 fully and to apply WHO's Global strategic directions on strengthening nursing and midwifery 2016–2020.¹ The Secretariat and Member States must translate the draft strategy from inspiration into real action.

The representative of PANAMA, acknowledging the importance of achieving universal health coverage and universal access to medicines, said that those medicines must be genuine and of good quality. To that end, primary health care must be strengthened by improving skills and addressing the social determinants of health. Communities must also be empowered to resolve their own health problems. It was essential to improve human resources development, particularly in remote areas. He called for improved regional cooperation for the provision of quality medicines in small countries that provided little incentive for the pharmaceutical industry because of their low sales volumes.

The representative of the UNITED STATES OF AMERICA strongly endorsed the concept of national health workforce accounts, as data were needed to evaluate the strategy and other global policy developments.

The representative of CHINA supported the policies presented in the draft resolution on the draft global strategy. However, she suggested adding an additional paragraph to the draft resolution stating that continued development of the health workforce was a priority. She endorsed the framework on integrated, people-centred health services, although research and development should correspond more closely to the targets in order to give Member States more concrete guidance and follow-up. More technical guidance was needed to implement the draft strategy, and implementation of the framework should be adjusted according to countries' individual situations.

The representative of SENEGAL said that the new campaign for people-centred health services marked a return to the principles of primary health care, centred on the family and community. Her country had revised its existing patient charter, which defined the roles, responsibilities and rights of health-care providers. As for the WHO Global Code, her country struggled to attract and retain health professionals – particularly in remote areas – which proved a greater problem than training them. Best practices must therefore be established to ensure efficient recruitment and buy-in of health workers.

The representative of MALAYSIA expressed particular support for the four strategic objectives contained in the draft global strategy and for the voluntary implementation of the WHO Global Code. In Malaysia, a draft national master plan for human resources would be published by the end of 2016.

The representative of COSTA RICA supported the draft global strategy, agreeing with the need to improve planning, investment and the alignment of policies with the population's needs, with a view to reducing inequality in access to health-care services and improving patient security.

¹ WHO. Global strategic directions for strengthening nursing and midwifery 2016–2020. Geneva: World Health Organization, May 2016 (http://www.who.int/hrh/nursing_midwifery/global-strategy-midwifery-2016-2020/en/, accessed 18 July 2016).

The representative of GUINEA, speaking on behalf of the Member States of the African Region, said that despite the significant progress made, there were imbalances across the Region and within countries. Work towards Sustainable Development Goal target 3.8 on universal health coverage required countries to adopt approaches that maximized efficiency and affordability. In that regard, a framework on integrated, people-centred health services was essential for meeting new challenges. Given that health systems were highly dependent on context, the framework adopted the correct approach by imposing not a single model, but five interdependent strategies. Time and political commitment would be needed to reach underserved and marginalized groups and to strengthen district-level health services. In the implementation of the framework, she called for a stronger focus on the essential role played by communities in providing primary health services. Efforts should be made to understand the possible effect of the framework on national health systems and the investments needed for its implementation, in particular regarding work to strengthen the health district as an operational unit.

The representative of MOROCCO supported the objectives of the draft global strategy. The critical shortage of health personnel was a barrier to health system reform in Morocco, prompting the adoption of a national action plan based on WHO recommendations and international regulations. While expressing strong support for the draft resolution and strategy, he said that success could only be achieved through concrete and realistic action plans and through regional and national strategies that were both adapted to the country and based on the global strategy. He requested WHO's support in that regard. A national priority was the establishment of a human resources observatory and mechanisms to control the migration of health professionals. Their retention had become a challenge for middle- and low-income countries, owing to the low remuneration and poor working conditions that they offered. In particular, emphasis should be placed on improving the productivity of health professionals, calling for a reform of the courses offered by medical schools.

The representative of JAPAN said that his country, as the host of the 42nd G7 Summit (Ise-Shima, Japan, 26 and 27 May 2016), intended to promote the global momentum for health systems strengthening. Health services could become fragmented when health systems were developed from the perspective of providers. The challenges of urbanization, ageing and rising health-care costs were predicted to become increasingly severe, calling for action upstream to guide the development of health service systems. He encouraged the Secretariat to provide technical support to Member States in the implementation of the framework.

The representative of NEW ZEALAND said that achievement of the Sustainable Development Goals called for health workforces that could participate in the planning, design and delivery of services that partnered people and communities, through primary health care focusing on prevention, protection, screening and early intervention. To that end, health workers needed a generalist scope of practice and sufficient depth and breadth of clinical and social knowledge and skills to provide value for money, working both within the health system and across different government agencies. Investment in the health workforce must be understood as an investment that benefited the economy of the country as a whole. Improved data must be obtained to assist analytics. WHO should provide support to countries in making evidence-based investment decisions using methods drawn from the field of economics, such as social benefits accounting and cost-benefit analysis, to achieve the best return on investment.

The representative of KENYA acknowledged the central role played by health workers in accelerating progress towards the health-related Sustainable Development Goals. She described some national initiatives intended to address the many challenges faced by Kenya's health workforce, particularly in rural, arid and semi-arid areas. She called on the Secretariat to give greater priority to creating awareness of the WHO Global Code and to increase technical support for its application at country and regional levels. She furthermore called on Member States to identify champions in

relevant national ministries to work alongside health ministries to develop an investment case for the implementation of the Global Code.

The representative of PAPUA NEW GUINEA called for further clarification of resolution WHA66.23, especially with regards to the standard protocol and assessment tool on health workforce education. The second phase of activity in 2016 to implement the resolution should provide for relevant government and multisectoral engagement. He endorsed the proposal to continue national reporting under the Global Code, with the addition of the aspects of health workforce development and sustainability. He supported adoption of the draft global strategy and the draft resolution, but asked for clarification as to how the various measures fitted together to achieve positive outcomes for all.

The representative of ARGENTINA stressed the need to promote the WHO Global Code by increasing funding, improving workforce planning and the combination of skills, and focusing on training and retaining health-care personnel. She highlighted the need to ensure equitable geographical distribution of health-care personnel, which would also entail addressing the issue of violence against health-care workers. Increasing health personnel numbers was particularly important in the least developed countries, and education needed to be standardized to ensure that future health-care professionals were able to respond to national needs. WHO should continue to collect the information required to evaluate trends in various institutions and countries, taking into account the specificities of each.

The representative of the RUSSIAN FEDERATION noted that the draft global strategy reflected goals set forth in the 2030 Agenda for Sustainable Development. In recent years, his country had striven to enhance the skills of its health-care personnel, standardize training for doctors and provide ongoing technical training and e-learning opportunities. Meanwhile, online job portals were making it easier for health-sector personnel to find employment. He fully supported the draft global strategy, which must, however, be implemented in ways that took into consideration the circumstances of individual countries.

The representative of ZIMBABWE welcomed the draft framework on integrated people-centred health services as part of broader efforts to promote primary health care, and recalled that the adoption of relevant instruments, including the Ouagadougou Declaration on Primary Health Care and Health Systems in Africa, had been instrumental in helping African Member States to promote their primary health-care sectors. The Director-General should continue to prioritize the four broad policy areas identified in resolution WHA62.12 (2009) on primary health care, including health system strengthening.

The representative of the REPUBLIC OF KOREA said that the transition to patient-centred care was likely to accelerate in tandem with advances in biotechnology and information technology, thereby ensuring that health services addressed people's needs more effectively. Her country had recently enacted the Patient Safety Act to encourage patients to make their voices heard, with a view to reducing the incidence of errors and accidents in the health-care sector, and was promoting the use of health information technology.

The representative of the UNITED REPUBLIC OF TANZANIA said that his country had succeeded in reducing the gap in its provision of human resources for health from 67% to nearly 50%, and in making progress in establishing a sustainable community health workforce. He commended the fact that the framework on integrated people-centred health services called for the provision of services in line with local preferences, but underscored that those preferences were not always in line with public health interests. Inadequate progress had been made with regard to the implementation of, and reporting on, the WHO Global Code; he called for efforts to identify the obstacles impeding implementation and reporting.

The representative of ECUADOR said that his country was committed to upholding the rights of health professionals, and was striving to combat discrimination and violence against health-care personnel so that they could work in safety and dignity. To improve health-care personnel management, accurate and up-to-date information was needed, including the number of health-care professionals working abroad. It was also crucial that university curriculums in the area of health were designed with a view to meeting the needs of both individuals and communities. The draft global strategy on human resources for health would help promote non-discriminatory and universal access to health-care services. In that regard, it was important that the strategy used the term “gender” rather than “sex”, as that would further underscore the importance of non-discrimination against health-care professionals, whose own sexual identification must always be acknowledged and accepted.

The representative of the DEMOCRATIC REPUBLIC OF THE CONGO said that a lack of suitably qualified health-care personnel in certain Member States meant that their populations were often treated by inadequately trained health-care providers, thereby undermining the provision of quality universal health coverage and the achievement of Sustainable Development Goal 3. It was to be hoped that the implementation by governments and other relevant stakeholders of the draft global strategy on human resources for health and the framework on integrated people-centred health services would promote interagency collaboration in the training and recruitment of health-care personnel.

The representative of INDONESIA said that the five interdependent strategies proposed in the framework on integrated people-centred health services were of great relevance to her country, an archipelago nation with limited health resources. To reach isolated and marginalized communities, Indonesia had developed a telemedicine programme and a flying health-care programme. Team-based strategies had also been adopted to address challenges related to the inequitable distribution and retention of health-care personnel. Furthermore, Indonesia had adopted a healthy-family programme to bolster community-based activities to promote health. Care must be taken to respect the views of local communities when implementing the proposed strategies.

The representative of the INTERNATIONAL ORGANIZATION FOR MIGRATION said that the migration of health professionals took several forms, including migrations from the south to the north of the world, between a country’s public and private sectors and from rural to urban areas. Conflicts and natural disasters weakened national health systems and caused operational challenges for health professionals, whose own safety was often compromised; their skills were often underutilized in transit and destination countries. Well managed migration of health professionals could play a key role in sustainable development, and could help to bolster health systems in destination countries and countries of origin. Effective bilateral and multilateral agreements on the international recruitment of health professionals, which also respected their freedom to migrate, were needed, and exchanges between professional diasporas, temporary placements in source country health systems, and mechanisms to facilitate the voluntary return of qualified professionals could help to improve training in countries of origin and bolster those countries’ health sectors. She commended the extensive data collection and analysis conducted under the National Reporting Instrument of the WHO Global Code but noted that gaps remained in areas such as the routine capture of migratory flows of health professionals, which could enhance the comparability and availability of data. Migrants, mobile populations and their families were often marginalized and underserved and must be included as empowered communities in participatory governance mechanisms on health.

The representative of the GLOBAL HEALTH COUNCIL, speaking at the invitation of the CHAIRMAN, said that a recent report by the Safeguarding Health in Conflict Coalition on attacks on health-care services in 2015 and early 2016 had highlighted that assaults, abductions and killings of health workers were widespread, as were attacks on the facilities where they worked. Furthermore, thousands of health workers had fled conflict areas, leaving countries deprived of the people they needed to provide desperately needed health services. The draft global strategy and accompanying

resolution recognized that protecting health workers was a key step in efforts to build health systems. Member States should report to the Secretariat on their actions to prevent attacks, as that would facilitate the Secretariat's work and provide useful guidance for other Member States with similar problems. The Secretariat should be given the resources required to compile systematic data on attacks on health workers and facilities.

The representative of the INTERNATIONAL COUNCIL OF NURSES, speaking at the invitation of the CHAIRMAN, said that strengthening human resources was a crucial step in efforts to bolster health systems and achieve the Sustainable Development Goals, and investment in nursing was an essential part of that strategy. It was estimated that, by 2030, there would be a shortage of 18 million health workers, which would primarily affect low- and middle-income countries. Countries must invest in the recruitment and retention of their health sector workforce and must ensure that adequate resources were made available for nursing services. Nurses played a vital role in early detection, intervention, surveillance, health promotion, disease prevention, care delivery and health literacy. She therefore urged the Secretariat and Member States to ensure that nurses were involved in every aspect of policy-making for the proposed health workforce strategies.

The representative of the WORLD MEDICAL ASSOCIATION, speaking at the invitation of the CHAIRMAN, welcomed the draft global strategy on human resources for health: workforce 2030, which recognized the crucial role of health workers in achieving universal health coverage and the Sustainable Development Goals. Governments had to recognize and protect the fundamental human rights of the health workforce by ensuring lack of discrimination, coercion and the growing trend for violence against health workers. He called on governments and local authorities to ensure that working conditions in rural health services were attractive enough to enable them to develop to the same extent as those in urban areas.

The representative of the TROPICAL HEALTH AND EDUCATION TRUST, speaking at the invitation of the CHAIRMAN, supported the renewed focus on universal health coverage in the Sustainable Development Goals, which would require rapid scaling-up of the recruitment, training and education of health workers. He urged Member States to support the use of health partnerships between institutions in developed countries and those in low- and middle-income countries to help to scale up the recruitment and training of health workers and achieve universal health coverage. They should also provide effective continuing professional development.

The representative of the WORLD CONFEDERATION FOR PHYSICAL THERAPY, speaking at the invitation of the CHAIRMAN, noted that, although rehabilitation professionals were important for reducing the prevalence and severity of illness and disability, appropriate workforce planning was hindered and the skill mix underused because of lack of data on the rehabilitation workforce. WHO had identified noncommunicable diseases as a growing burden on health services, but physical therapy was both clinically effective and cost-effective in reducing the need for more expensive interventions, and its more widespread use would help countries to provide the services needed. He also stressed the clinical and cost benefits of direct access to patients without referral by a third party.

The representative of INTRAHEALTH INTERNATIONAL INC., speaking at the invitation of the CHAIRMAN, urged approval of the draft global strategy, for which an implementation plan was needed to help to drive the investment and policies required to achieve the Sustainable Development Goals. Increased investment in a strong health workforce able to respond to changing demographic trends and prevent, detect and respond to future epidemics was needed to bring about a healthier world.

The representative of the INTERNATIONAL FEDERATION OF MEDICAL STUDENTS' ASSOCIATIONS, speaking at the invitation of the CHAIRMAN, urged Member States to give adequate attention to the impact of health workforce strategies on medical education and patient outcomes, and to ensure the quality of that education through mandatory accreditation of academic institutions according to World Federation for Medical Education's global standards. Member States should involve all stakeholders in decision-making processes, especially medical students, young physicians in training and academic institutions.

The representative of MEDICUS MUNDI INTERNATIONAL – INTERNATIONAL ORGANISATION FOR COOPERATION IN HEALTH CARE, speaking at the invitation of the CHAIRMAN, said that a competent workforce improved health outcomes, reduced health inequalities and helped to guarantee the right to health. The draft global strategy was not sufficiently explicit about implementation and failed to address the crucial question of the nature of the health system in which health workers provided care. The best health outcomes were achieved through investment in public health systems and she therefore urged Member States to include implementation, governance and financing mechanism in the strategy. The expansion and allocation of the health workforce should not be left to the labour market. Member States had a duty to provide technical and financial assistance for other governments to ensure full enjoyment of the right to health.

The representative of the INTERNATIONAL PHARMACEUTICAL STUDENTS' FEDERATION, speaking at the invitation of the CHAIRMAN, emphasized establishing universal accreditation systems for pharmacy education. There was a shortage of competent pharmacists; she urged Member States to establish standards for pharmacy curriculums and lay down core competencies for entry-level pharmacists worldwide. If they were to halve their dependence on foreign-trained health professionals by 2030, Member States must provide an adequate training infrastructure, a robust quality control system, and better pay and conditions for pharmacists. She urged WHO to include pharmacy practice in the implementation of the global strategy.

The representative of the INTERNATIONAL PHARMACEUTICAL FEDERATION, speaking at the invitation of the CHAIRMAN, called upon governments to include pharmacists in their national human resources for health strategies. Pharmacy workforce development required proper planning to ensure the delivery of services according to national and local needs. Her federation would host the Global Conference on Pharmacy and Pharmaceutical Sciences Education in China in November 2016, where it was hoped a clear road map would be adopted to advance education and training.

The representative of the INTERNATIONAL CONFEDERATION OF MIDWIVES, speaking at the invitation of the CHAIRMAN, said that it was essential for health-care professional associations to be involved in tackling massive health workforce shortages because they were uniquely placed to provide insights that could not be gained elsewhere. In order to develop sustainable and realistic workforce strategies that addressed shortages, improved distribution of health workers and maximized improvements in health outcomes, Member States should include representatives of the health-care professions at every step of relevant policy-making and implementation.

The representative of the INTERNATIONAL FEDERATION FOR MEDICAL AND BIOLOGICAL ENGINEERING, speaking at the invitation of the CHAIRMAN, pointed out that the health workforce did not consist only of physicians, nurses and midwives, and highlighted the essential role of health care technologists. For example, medical devices played a vital role in many areas and were operated by biomedical and clinical engineers, physicists, technicians and others. Effective people-centred care required appropriate medical information and communications technology applications, such as electronic medical records. He strongly recommended that WHO expand its own global staff for medical devices and other non-drug technologies by establishing

professional teams at headquarters and in the regions to reflect the growing importance of medical devices and the related staff in integrated solutions.

The observer of CHINESE TAIPEI outlined some of the challenges Chinese Taipei faced in recruiting and retaining medical personnel and the various steps taken to address the situation, such as offering incentives and improving working conditions, in order to reduce the medical services gap between urban and rural areas.

The ASSISTANT DIRECTOR-GENERAL (Health Systems and Innovation), responding to points made, said that a report on the implementation of resolution WHA66.23 (2013) on transforming health workforce education in support of universal health coverage, was planned for 2017. Implementation of the WHO Global Code was an ongoing process, and the Secretariat would follow up on the request to review technical criteria for defining shortages of health workers. The Secretariat was working as an integrated team on health system strengthening, squarely linking health financing, service delivery, access to medicines and workforce issues and facilitated by the joint implementation of the Universal Health Coverage Partnership with the European Union and Luxembourg. Synergies were also being made with the WHO Health Emergencies Programme and with efforts to strengthen core capacities required by the International Health Regulations (2005). She acknowledged that more work was needed to define appropriate indicators for the framework on integrated, people-centred health services. A diagram produced by the Secretariat showing the relationship between the framework on integrated, people-centred health services and other current WHO global strategies was available online. The need to adapt the framework to national contexts was recognized, and the Secretariat stood ready to help Member States to work on their national strategies. The Secretariat would follow up on the specific request to continue implementing resolution WHA66.23 in the area of educating health-care workers. She expressed appreciation for the leadership shown by the Presidents of France and South Africa in co-chairing the High-Level Commission on Health Employment and Economic Growth.

The Committee noted the reports contained in documents A69/36, A69/37, A69/37 Add.1, A69/38 and A69/39.

The CHAIRMAN took it that the Committee wished to approve the draft resolution on the global strategy on human resources for health introduced at the Committee's third meeting.

The draft resolution was approved.¹

The CHAIRMAN asked whether the Committee wished to approve the draft resolution on strengthening integrated, people-centred health services, introduced at the current meeting.

The representative of CANADA said that, as the text of the draft resolution had changed from that contained in resolution EB138.R2, additional time would be required to discuss the amendments with technical experts. She therefore requested that consideration of the draft resolution be suspended.

It was so agreed.

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

¹ Transmitted to the Health Assembly in the Committee's third report and adopted as resolution WHA69.19.

Follow-up to the report of the Consultative Expert Working Group on Research and Development: Financing and Coordination – Report of the open-ended meeting of Member States: Item 16.2 of the agenda (document A69/40) (continued from the first meeting, section 4)

The representative of INDIA, speaking in his capacity as chairman of the informal working group established to discuss the agenda item, reported that considerable ground had been covered in the group's discussions. A draft resolution would be submitted to the Committee in due course.

The representative of ANGOLA, speaking on behalf of the Member States of the African Region, took note of progress in implementing resolution WHA66.22 (2013) on follow-up to the report of the Consultative Expert Working Group, particularly with regard to the demonstration version of the Global Observatory on Health Research and Development, health research and development demonstration projects, and the creation of a specific budget line, the funding gap for which must be filled. There was a need for a more sustainable financing mechanism for health research and development in the Region. The report of the open-ended meeting recognized the lack of global coordination of research and development for major diseases and called for WHO to play a more active role in that regard.

In view of concerns about the inappropriate use of antibiotics in human medicine and insufficient investment in developing new antibiotics, he applauded the recent establishment of the Global Antibiotic Research and Development Facility and asked for further details about it, the role of the Board of Directors of the Drugs for Neglected Diseases initiative and the expected role of WHO in the new Facility.

A more coherent policy framework for the financing and coordination of research and development was needed to ensure a sustainable research system that responded to national, regional and global priorities. The African regional health research strategy for 2016–2025 would contribute to that aim, but implementation thereof would require further technical support from the Secretariat.

The representative of the BOLIVARIAN REPUBLIC OF VENEZUELA, speaking on behalf of the Member States belonging to the Union of South American Nations (UNASUR) and supported by the representative of ARGENTINA, said that implementation of resolution WHA66.22 should continue with full participation from public and private bodies, academia and civil society. The recommendations made by the Consultative Expert Working Group were important for other areas of the Organization's work. Proper coordination of research and development required links among the various initiatives concerned and should be guided by context, aims, principles and the eight elements of WHO's Global strategy and plan of action on public health, innovation and intellectual property, as well as by the Group's recommendations. Work should continue in the search for alternative and innovative solutions to ensure sustainable, predictable and adequate funding.

Medicines to treat a range of diseases could be made more affordable if the right incentives were provided to encourage innovations that responded to health needs and to delink retail prices from research and development costs. Intellectual property rights had not proved an effective incentive to promote research and development in the area of diseases that mainly affected developing countries and alternatives were therefore needed. He expressed support for the development of an overall framework to identify rules, priorities and best practices for research and development. It was important to pursue a coherent approach to the subject, reflecting the various WHO workplans and initiatives. The Consultative Expert Working Group should continue its discussions with a view to reducing inconsistencies among the intellectual property, human rights and trade frameworks.

The representative of MEXICO said that WHO had an essential role in coordinating and facilitating research and development in the area of health technologies. Efforts in that area should be consistent with measures to implement the 2030 Agenda for Sustainable Development and the Addis Ababa Action Agenda of the Third International Conference on Financing for Development.

The representative of the UNITED STATES OF AMERICA, expressing disappointment at the slow progress in securing financing for demonstration projects, said that factors contributing to such a lack of enthusiasm should be identified and addressed. In its future activities in the area of research and development, WHO must work with all sectors. Its primary role should be to engage a broad range of stakeholders, including academia, foundations and the public and private sectors, so as to ensure that credible recommendations could be made.

The meeting rose at 12:30.

FIFTH MEETING

Friday, 27 May 2016, at 14:35

Chairman: Dr M. KIFLE (Ethiopia)
later: Dr PHUSIT PRAKONGSAI (Thailand)

HEALTH SYSTEMS: Item 16 of the agenda (continued) [transferred from Committee A]¹

Follow-up to the report of the Consultative Expert Working Group on Research and Development: Financing and Coordination – Report of the open-ended meeting of Member States: Item 16.2 of the agenda (document A69/40) (continued)

The representative of SWITZERLAND said that it was regrettable that more progress had not been made towards establishing a suitable system for funding and coordinating health research and development. She welcomed the establishment of the Global Observatory on Health Research and Development, the development of a conceptual framework for the pooled fund for voluntary contributions, and the fact that funding had been secured for some of the demonstration projects. However, the pool of contributors was limited, funding had not been secured for all demonstration projects and the Global Observatory continued to lack the funding it required. In order to make further progress, it was necessary to focus on the principle of shared responsibility, with greater involvement of middle- and low-income countries. She welcomed the contributions made by Brazil, India and South Africa to the pooled fund, but pointed out that Switzerland's contribution of US\$ 1.5 million in matching funds remained unused.

The research and development agenda could not afford to fail, especially since it was an integral part of the 2030 Agenda for Sustainable Development. Thus, it was essential to continue developing and to secure sustainable funding for the Global Observatory, establish a priority-setting procedure for health research and development, draw up a new plan for the implementation of the voluntary pooled funding mechanism, and mobilize additional funding for demonstration projects. Political will on the part of all would be needed to achieve those objectives. Member States must take action to ensure that people suffering from neglected tropical diseases would, at last, have access to needed medicines.

The representative of SOUTH AFRICA expressed satisfaction with the progress reported. The coordination mechanism would enhance policy coherence in research and development work, and would contribute to achieving Sustainable Development Goal 3 on healthy lives for all. The Global Observatory had an important role to play in monitoring and providing needed information. However, care must be taken to ensure that work on other aspects of the strategic workplan agreed under resolution WHA66.22 (2013) was not neglected or delayed while the Global Observatory was being consolidated. It was disappointing that funding had been allocated for only three demonstration projects; there should be a clear and transparent method of allocating resources. The funding gap required urgent attention.

He supported the inclusion of funding for health research and development in the financing dialogue. A voluntary financing mechanism was unlikely to be sustainable and could hamper progress. The voluntary financing system should be reviewed after a trial period and, if it had proved ineffective, a mandatory approach should be considered. Greater commitment from Member States

¹ See the summary record of the General Committee, first meeting, section 2.

and partners was needed to finance the full implementation of the important work on research and development. He supported the draft resolution.

The representative of the DEMOCRATIC REPUBLIC OF THE CONGO, welcoming the Expert Working Group's recommendations put forward in its report, said that research could contribute to a wide range of issues relating to the achievement of universal health coverage. Given the scarcity of resources, it was essential for countries to establish partnerships with research institutions to identify priority areas where research was needed to provide evidence to inform health policy-making.

The representative of IRAQ said that resources for research and development should be allocated from the biennial budget at regional and country levels.

The observer of CHINESE TAIPEI wholeheartedly supported the plan to strengthen international health research and development capacity and invest in research on diseases disproportionately affecting developing countries. The improvement of monitoring mechanisms and coordination would be important steps towards ensuring sustainable funding for that purpose. Chinese Taipei was prepared to increase investment in health research and development and to share its research technologies, including its capacity to develop and produce a wide range of vaccines and medicines. It was currently focusing on the development of new tools and technologies for the control of dengue. Chinese Taipei wished to play an active role in building a more resilient global health system with a view to achieving universal health coverage.

The representative of MÉDECINS SANS FRONTIÈRES INTERNATIONAL, speaking at the invitation of the CHAIRMAN, said that the decision of the United Nations Secretary-General to launch a High-Level Panel on Access to Medicines had highlighted the failings of the research and development system. Access to medicines was a global challenge and a structural problem that could not be addressed by countries acting alone; global coordination and agreement were needed. Research and development must be needs-driven and evidence-based and its cost must be de-linked from market prices. Ensuring affordable, efficient and equitable access to medicines should be seen as a shared responsibility. Decisive action was needed, particularly on the part of governments. The broken research and development system was a problem that governments had created and one that, ultimately, only they could solve. She urged Member States to commit to organizing an intergovernmental conference on research and development before the Seventieth World Health Assembly in 2017 with the aim of ensuring policy coherence.

The representative of STICHTING HEALTH ACTION INTERNATIONAL, speaking at the invitation of the CHAIRMAN, said that de-linking research and development costs from drug prices could promote greater openness and exchange of knowledge and ensure that research and development investments were more cost-effective and responsive to the needs of patients and of society. If the current global research and development financing system, which depended on monopolies and high prices, was to be replaced, new ways of funding research and development must be found and global agreements on funding reached. However, it was difficult to persuade governments to fund research and development. WHO should convene a meeting to identify incentives for inducing Member States to fund medical research and development as a public good. The Global Observatory should be adequately funded and should collect and publish data on research and development costs, as well as the terms of licences for publicly funded research and development.

The representative of MEDICUS MUNDI INTERNATIONAL – INTERNATIONAL ORGANISATION FOR COOPERATION IN HEALTH CARE, speaking at the invitation of the CHAIRMAN, said that a sustainable research and development system must be guided by the principles of effectiveness, efficiency and equity and grounded in the concepts of de-linkage and

knowledge-sharing. The Global Observatory's work should form part of a broader framework, encompassing not only neglected tropical diseases, but also antimicrobial resistance and noncommunicable diseases. Policy coherence and effective coordination should be ensured among all WHO-led research and development initiatives, including the proposed research blueprint for emerging pathogens and the global action plan on antimicrobial resistance. He urged Member States to send a clear message by acknowledging that the current monopoly-based system was unsustainable and limited access to medicines for those in need and to take decisive action. The world could not afford 10 more years of idle discussions.

The representative of the INTERNATIONAL FEDERATION OF PHARMACEUTICAL MANUFACTURERS, speaking at the invitation of the CHAIRMAN, said that it was necessary to focus on practical and politically feasible proposals. Protection of intellectual property rights remained central to the development of new medicines. Nevertheless, new models, such as product development partnerships and patent pooling, had yielded positive outcomes in patients' access to medicines. Such collaborative approaches had led to real progress in tackling HIV, malaria and neglected tropical diseases. Future solutions should be designed to meet specific problems; a one-size-fits-all approach would not work. Overcoming barriers to access should be achieved through a holistic approach, encompassing not only research and development models, but also financing, investment in infrastructure and enhancement of workforce capacity.

The representative of the DRUGS FOR NEGLECTED DISEASES INITIATIVE, speaking at the invitation of the CHAIRMAN, said that the current discussion offered an opportunity to consider four actions for redressing the failures of the current system for financing medical innovation and for putting in place a sustainable and efficient innovation system. To that end, Member States should consider requesting the Secretariat to establish a priority-setting mechanism; ensure that the Global Observatory was sustainably funded and covered all important areas of public health; ensure that pooled funds covered all areas of need, focused on agreed priorities and applied the principles advocated by the Consultative Expert Working Group, including de-linkage; and develop an overarching framework covering all research and development stakeholders and all areas of public health importance. It should also be asked to organize an intergovernmental conference on policy coherence in the field of research and development.

The ASSISTANT DIRECTOR-GENERAL (Health Systems and Innovation) acknowledged the undoubted progress since 2013, but lack of funding, especially for the implementation of the demonstration projects, remained a major obstacle. Responding to specific points raised in the discussion, she said that the aim of the Global Antibiotic Research and Development Partnership was to develop new antibiotic treatments, promote responsible use of antibiotics and ensure access to those medicines for all. The Partnership's incubation project was a joint undertaking of WHO and the Drugs for Neglected Diseases initiative, which aimed to achieve some of the objectives of WHO's global action plan on antimicrobial resistance. In December 2015, the Board of Directors of the Drugs for Neglected Diseases initiative had agreed to host the Partnership for a start-up phase of two years and to provide the necessary scientific environment and infrastructure to ensure an effective incubation period. During that period, the project would come under the current governance structure of the Drugs for Neglected Diseases initiative; no decision had been made as yet about future governance arrangements. WHO would provide technical input on the identification of global health needs, financing strategies, target product profiles, the identification of research and development portfolios, the governance structure of a future entity, and access and conservation strategies for new antimicrobial medicines.

Important roles for WHO in the field of research and development included convening stakeholders, taking the lead in analysing research gaps – the responsibility of the new Global Observatory, and making recommendations on priorities through the proposed coordination mechanism. The Secretariat was willing to assume responsibility for those roles. Supporting research

and development for Type II and Type III diseases, and for the specific needs of developing countries with regard to Type I diseases, was the shared responsibility of all countries, rich and poor. That mandate had been reinforced by the commitment made by all countries to meeting the Sustainable Development Goals. She called upon all Member States to support the important work under way, especially the demonstration projects. Although the financial shortfall of just over US\$ 70 million seemed huge, it was a mere drop in the ocean of global investment in research and development.

The CHAIRMAN said that consideration of the draft resolution on the item would be deferred until the drafting group had completed its work.

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

Dr Phusit Prakongsai took the Chair.

Substandard/spurious/falsely-labelled/falsified/counterfeit medical products: Item 16.3 of the agenda (document A69/41)

The representative of NIGERIA, speaking on behalf of the Member States of the African Region, said that the circulation of substandard/spurious/falsely-labelled/falsified/counterfeit (SSFFC) medical products had increased to such an extent that it severely threatened public health in the African Region. Significant steps had been taken by the Region to tackle SSFFC medical products, including the establishment of a regional plan of action, the establishment of the Medicines Anti-Counterfeit Committee of the Economic Community of West African States, and the introduction of the WHO global surveillance and monitoring system in more than 33 Member States.

In total, 46% of all reported cases of SSFFC medical products were from the African Region, consisting mainly of antimalarial, antiparasitic, antibiotic and emergency contraceptive medical products, some of which had been falsely labelled as WHO-prequalified products. To counter the negative impact of SSFFC medical products on public health and socioeconomic development, there was a need to build capacity to ensure oversight and regulation; put in place single points of contact and build national capacity, including in the use of information and communication technology to track and trace those products; build effective collaboration in oversight within and between Member States to ensure the security of the supply chain; and strengthen the capacity of regulatory authorities and national quality control laboratories. Support was also needed to enable countries to meet their requirements in relation to medical products and to strengthen national ownership of control mechanisms. The Secretariat should ensure sufficient funding for the Member State mechanism.

The representative of the BOLIVARIAN REPUBLIC OF VENEZUELA, speaking on behalf of the Member States of the Union of South American Nations, said that the Member State mechanism had yielded significant results, including valuable guidance on track and trace models and recommendations for detecting and dealing with actions, activities and behaviours that could give rise to SSFFC medical products. The mechanism's work should be supported by the Secretariat, and transparency and a focus on public health should be ensured. The latter was of crucial importance in the context of WHO's interaction with non-State actors and the emergence of external initiatives that sought to link the debate on SSFFC medical products with third parties whose interests were not always consistent with public health interests. The work of the mechanism must remain within WHO in order to ensure a continued focus on public health. He urged the Secretariat and Member States to redouble their efforts to ensure the allocation of sufficient resources to enable the mechanism to continue to operate.

The representative of IRAQ highlighted WHO's role in the sponsorship of companies producing drugs and medical products and the need for regular reporting thereon. WHO should support capacity-

building in Member States for registration of medicines, vaccines and other medical products. Capacity-building was also needed to enhance monitoring and evaluation of medical products and the capacity of quality control laboratory personnel. With the support of WHO, knowledge should be exchanged at the intra- and inter-regional levels. Community health education on the issue was also vital.

The representative of INDIA said that the recent establishment of the global focal point network on SSFFC medical products would facilitate the timely exchange of information among national medical regulatory authorities. In addition, the finalized draft document on track and trace technologies (document A69/41, Appendix 2) would assist Member States in selecting the appropriate technology for the national context. He welcomed the decision to establish a working group of experts on refining the working definitions of SSFFC medical products, which would bring much needed clarity and a shared understanding, which in turn would increase the transparency of the activities of the WHO global surveillance and monitoring project. It would also provide needed guidance to other United Nations bodies working in the area of SSFFC medical products.

The document on the actions, activities and behaviours that fell outside the mandate of the Member State mechanism, for which India was responsible, had not yet been finalized. The issue of transit, in particular, required further discussion, particularly given the recent trend to include provisions relating to in-transit scrutiny in regional regulations and trade agreements, which might conflate the issue of trademark infringements with that of SSFFC medical products and thereby hinder access to legitimate generic medicines. Regulatory capacity should be strengthened in order to enforce appropriate quality control; at the same, measures should be taken to improve access to affordable, high-quality medicines. He welcomed the proposed study to increase the understanding of the links between the prevalence of SSFFC medical products and lack of access to affordable medicines.

The representative of INDONESIA, welcoming the effort to refine the definitions used in the work on SSFFC medical products, said that, in order to eradicate such products, a multistakeholder approach was essential, as was effective risk communication and awareness-raising. A robust system to identify such products had been introduced at the national level and a single point of contact had been established. A clear identification of the activities that fell within and outside the mandate of the Member State mechanism was needed to minimize the risk of inefficient use of resources.

The representative of the REPUBLIC OF KOREA said that, in order to halt the distribution of illegal medical products, Member States needed to cooperate closely and reach consensus on a clear definition of SSFFC medical products and on the best ways to regulate them. Monitoring systems, including quality control mechanisms and “track and trace” processes, should be established at the local level. Her country had implemented a range of measures to tackle SSFFC medical products, such as the introduction of strict measures to prevent the entry of illegal medical products, promotion of the safe use of medical products and collaboration with industry to encourage self-regulation. It was participating actively in international collaborative efforts to eradicate SSFFC medical products.

The representative of the PHILIPPINES, referring to her Government’s active involvement in discussions on the WHO MedNet platform, said that a forum for information-sharing and dialogue among national regulatory authorities would enhance efforts to combat SSFFC medical products. The recommendations to be developed by the proposed working group on effective risk communication and awareness-raising campaigns would enhance existing national advocacy activities. Efforts to tackle SSFFC medical products must focus on demand as well as supply. The proposed study on the public health and socioeconomic impact of SSFFC medical products would be a useful tool to provide an accurate picture of the scope and extent of the problem and to guide future efforts.

The representative of the UNITED REPUBLIC OF TANZANIA, welcoming the creation of a focal point network for consultation and the exchange of information and the publication of the draft

document on track and trace technologies, called on the Secretariat and the Member State mechanism to expedite the completion of that work. His Government had taken steps to strengthen the national medicines regulatory system and had played a leading role in the implementation of the East African Community Medicines Regulatory Harmonization Programme. A national plan of action to combat SSFFC medical products would be finalized in 2016. He urged the Secretariat and the mechanism to fast-track the finalization of the framework/guidelines on developing a national plan for preventing, detecting and responding to SSFFC medical products, and called for additional funding to sustain the work of the mechanism and the Secretariat on the issue.

The representative of KENYA commended the efforts of the Secretariat and the Member State mechanism in tackling SSFFC medical products and encouraged Member States to continue supporting those efforts. He welcomed the establishment of the global focal point network for the exchange of information and consultation and urged Member States to consider adopting the existing set of global identification and serialization standards.

The representative of SRI LANKA said that the establishment of global and regional networks connecting customs and border protection officials would serve to enhance collaboration and information-sharing and help to prevent smuggling and other illegal activities. An effective global drug-testing laboratory network should also be established. Educating the public on the issue of SSFFC medical products was also important.

The representative of ETHIOPIA said that a range of intervention strategies had been implemented in his country based on the findings of a recent national study conducted in collaboration with WHO on the status of SSFFC medical products, including the revision and strengthening of regulatory legislation, the reinforcement of import and export procedures and increased cross-border collaboration. Nevertheless, challenges remained. Acknowledging the efforts of the Director-General and the Member State mechanism, he called for priority to be accorded to enhancing technologies for detecting SSFFC medical products. His Government remained committed to the work of the mechanism.

The representative of THAILAND said that the global focal point network would provide a vital link with the WHO global surveillance and monitoring system for SSFFC medical products. Lack of clear definitions had hindered the work on such products, and she therefore encouraged the Secretariat and the Member State mechanism to accord priority to refining the working definitions. Member States should submit timely feedback for the review of the mechanism to be conducted in 2017, pursuant to resolution WHA65.19 (2012).

The representative of NIGER said that her Government had launched an extensive campaign to raise public awareness of SSFFC medical products. In order to eradicate such products, WHO should support countries in establishing a multisectoral approach with multistakeholder involvement, including ministries of trade and law enforcement and customs authorities.

The representative of SENEGAL noted that his country was a member of the Member State mechanism and actively participating in the working group tasked with developing and leveraging existing recommendations for effective risk communication and for awareness campaigns on SSFFC medical products and related actions, activities and behaviours. His Government had established a national committee to tackle such products and illegal pharmacy practices and was developing a national awareness-raising programme. He called on the Secretariat to make available increased resources to enable all countries to more effectively combat the scourge of SSFFC medical products.

The representative of CHINA underlined the need for a standardized approach to the value chain, in addition to early detection and control of SSFFC medical products. Technical exchanges on

detection and risk assessment should be encouraged and the work on refining the definitions of SSFFC medical products should be completed as soon as possible. His Government was developing guidelines to combat such products based on experience and best practices. China stood ready to continue working with other Member States to tackle the problem of SSFFC medical products and encouraged increased international cooperation.

The representative of SOUTH AFRICA expressed support for the proposals to develop guidelines for national plans for preventing, detecting and responding to the threats posed by SSFFC medical products, which would harmonize the procedures to be adopted. The guidelines might also be incorporated into national legislation. She also supported the establishment of a global focal point network which, by facilitating information-sharing among Member States, would allow the extent of the problem to be understood and interventions to be designed. The information on track and trace models was welcome. Implementing such systems was complex and costly, however, and low-cost options should be explored. Member States and manufacturing companies would need to agree on a common system that could be easily used by all. Member States should, as a matter of priority, submit training materials to be incorporated into the guidelines under development and appoint focal points for information-sharing.

The representative of ARGENTINA said that it was not clear whether the terms of reference for the global focal point network contained in Appendix 1 to the Member State mechanism's report were definitive or were intended to serve as a starting point for discussion. The proposed study on the public health and socioeconomic impacts of SSFFC medical products would require a robust methodological framework. The Member State mechanism should continue working to reach consensus on key issues, such as the transit of SSFFC medical products, which could have an impact on the international circulation of generic active ingredients. She supported the Member State mechanism's decision to allow the Secretariat to observe on a provisional basis meetings of the global steering committee for quality assurance for health products. As requested by the mechanism, the Secretariat should provide a report on the global steering committee, including documents and information on its nature, legal status, governance and participants.

The representative of BURUNDI said that, although the development of generic pharmaceuticals had improved access to and reduced the price of medicines, the parallel rise in false and counterfeit products had caused a rise in deaths and iatrogenic illnesses. In Burundi, concrete measures had been taken to tackle the problem, including independent laboratory testing of medicines purchased with public funds; the publication of a quality assurance manual for essential medicines; a system to ensure the quality of medicines for malaria, HIV and tuberculosis; and random sampling and testing of medicines at the point of distribution.

The representative of TUNISIA said that the global focal point network would facilitate information exchange and improve monitoring of SSFFC medical products. Countries should establish national mechanisms and laws to prevent the distribution of such products. Her country had launched a programme to monitor the production of a wide range of medical products and was also monitoring the provision of medicines at dispensary level.

The representative of MALAYSIA said that her country used security labels to help to identify SSFFC medical products and planned to introduce a track and trace system. She hoped that the Secretariat would help to coordinate further dialogue on such systems so that Member States could find a common platform and make better use of information technology to counter SSFFC medical products.

The representative of MOROCCO said that his Government had taken several measures to ensure access to high-quality medicines, including the establishment of a price control system and the

introduction of regulations facilitating the registration of generic medicines. Morocco had ratified the Council of Europe Convention on the Counterfeiting of Medical Products and Similar Crimes involving Threats to Public Health in 2016.

The representative of COSTA RICA, referring to the proposed terms of reference for the global focal point network contained in Appendix 1 to the Member State mechanism's report, proposed several modifications to the provisions regarding the designation of focal points. Subparagraph 7(b) should encourage Member States always to designate a deputy focal point who could perform the functions of the focal point in the event that the latter was not available. The two officials should be appointed by the highest authority within the institution that was to house the focal point. Subparagraph 7(f) should indicate that the nominated national focal point must be trained on the use of the WHO global surveillance and monitoring system. Likewise, subparagraph 7(i) should state that focal points must be trained in the use of an electronic platform to be created and administered by the WHO Secretariat. The current text read "should be trained" in both cases, but focal points should be required to have such training.

The representative of the RUSSIAN FEDERATION said that her Government supported the establishment of intergovernmental policy and the exchange of information on SSFFC medical products. It was important to support the future development of the monitoring and surveillance system as a structural component of national plans to monitor pharmaceutical products and detect SSFFC medical products and other measures to minimize the risks posed by such products to public health. The Russian Federation was, on the basis of WHO recommendations, planning to introduce a track and trace system.

The observer of CHINESE TAIPEI said that attempts to prevent the circulation of SSFFC medical products could not rely solely on the power of health authorities; other departments must also be involved. Chinese Taipei had enhanced its inspection system and planned to introduce a traceability system. It was also conducting outreach activities to inform the public about SSFFC medical products and the safety of medicines. Through a series of integrated efforts, the problem of SSFFC medical products had been significantly reduced in Chinese Taipei.

The representative of the INTERNATIONAL PHARMACEUTICAL FEDERATION, speaking at the invitation of the CHAIRMAN, welcomed the development of track and trace models and viewed with interest the development of initiatives aimed at authenticating medicines at the point of dispensing or purchase. Such tools, especially when developed in collaboration with health professionals, could help to improve vigilance and enhance confidence in medicines. WHO's medical product alerts could serve as important tools for health professionals. A similar initiative for medical and dental devices would be welcome. To address the lack of awareness of the risks associated with obtaining medicines through unsafe, illegal or non-legitimate sources, the World Health Professions Alliance was developing interactive educational videos, which would be available in mid-2016.

The representative of the INTERNATIONAL FEDERATION OF MEDICAL STUDENTS' ASSOCIATIONS, speaking at the invitation of the CHAIRMAN, said that SSFFC medical products could undermine trust in health systems and compromise physicians' ability to build strong therapeutic alliances with their patients. Action to tackle the problem should not only target the supply side of the issue, but also involve stakeholders on the demand side. She called on governments to promote professional education on SSFFC medical products for health workers, many of whom lacked knowledge on the issue, and to develop an effective public outreach and education campaign to inform consumers about the health risks of such products.

The representative of MEDICUS MUNDI INTERNATIONAL – INTERNATIONAL ORGANISATION FOR COOPERATION IN HEALTH CARE, speaking at the invitation of the CHAIRMAN, said that the broad term “counterfeit” inappropriately conflated the public health problem of spurious and substandard medicines with asserted breaches of intellectual property rights. The confusion of efficacious and affordable generic medicines with substandard products had led Member States to adopt measures that reduced access to vital medicines. The term “SSFFC” had been in use for six years, although it was supposed to have been temporary. Lack of a clear definition was hindering evidence-based policy-making. She urged the Secretariat to publish the complete datasets and methodology applied in the recently commissioned socioeconomic impact study on SSFFC medical products in order to ensure transparency. She also urged it to reflect critically on whether its participation in the global steering committee for quality assurance of health products might run counter to its efforts to ensure impartial approaches to SSFFC medical products.

The representative of the INTERNATIONAL PHARMACEUTICAL STUDENTS’ FEDERATION, speaking at the invitation of the CHAIRMAN, said that the Fight the Fakes initiative, in which her organization was a partner, offered support to Member States in increasing awareness and understanding of, and protecting patients from, fake medicines. Coordination among all actors was vital to tackle the risk posed by SSFFC medical products to public health. She welcomed the efforts of the Member State mechanism in exchanging best practices and experiences at the national, regional and global levels. Her organization was ready to contribute to those efforts and share expertise.

The ASSISTANT DIRECTOR-GENERAL (Health Systems and Innovation), expressing gratitude to the members of the Member State mechanism for their hard work, said that strong participation by technical experts from national regulatory authorities from all regions in the various working groups was needed. The Secretariat would continue to expand the global surveillance and monitoring system for SSFFC medical products. To date, 115 national regulatory authorities had been trained in the use of the system, and more than 1100 SSFFC medical products had been reported in the first three years. Further regional workshops were planned to train more personnel in the use of the system. The system would provide technical support and practical tools while gradually accumulating a body of evidence which could be used to improve vigilance and focus investment.

Responding to specific points, she said that the Secretariat recognized the need to maintain transparency and exclude commercial interests. It looked forward to working with technical experts from all Member States to improve and refine definitions. The final draft of the socioeconomic study would be submitted to the Member State mechanism by the end of 2016. Work was under way to improve capacity in laboratory facilities. Communication, awareness-raising and collaboration were the first steps in combatting the global problem of SSFFC medical products. She looked forward to the results of the review of the Member State mechanism, which would be reported to the Seventieth World Health Assembly in May 2017. She thanked Member States that had contributed funding and in-kind support to the mechanism and affirmed the Secretariat’s commitment to engaging in dialogue with Member States on how to ensure adequate future funding.

The Committee noted the report.

Addressing the global shortages of medicines, and the safety and accessibility of children’s medication: Item 16.4 of the agenda (document A69/42)

The CHAIRMAN said that two draft resolutions had been proposed for consideration under the agenda item. The first, on promoting innovation and access to quality, safe, efficacious and affordable medicines for children, had been proposed by the delegations of China, Malaysia, Pakistan and Thailand and read:

The Sixty-ninth World Health Assembly,

PP1 Having considered the report on addressing the global shortages of medicines, and the safety and accessibility of children's medication;¹

PP2 Recalling resolution WHA60.20 (2007) on better medicines for children and WHA67.22 (2014) on access to essential medicines, which identified actions for Member States and the Director-General in support of better access for children to essential medicines;

PP3 Recalling also resolution WHA67.20 (2014) on regulatory system strengthening for medical products and its relevance for promoting safety, accessibility and affordability of medicines for children;

PP4 Concerned about the lack of access to quality, safe, effective and affordable medicines for children in appropriate dosage forms and problems with rational use of children's medicines in many countries, and that, globally, children under age five still do not have secure access to medicines that treat pneumonia, tuberculosis, diarrhoeal diseases, HIV infection, AIDS and malaria, as well as medicines for many other infectious diseases, noncommunicable diseases and rare diseases;

PP5 Concerned about the lack of research and development on age appropriate dosage forms most suitable for children as well as for new medicines for diseases that affect children, that are appropriate for use in all environments, including areas lacking access to clean water;

PP6 Aware that an important factor linked to morbidity and mortality of children is the lack of safe, effective, affordable and quality-assured medicines for children, and in some circumstances, lack of packaging in child-proof containers;

PP7 Noting that despite sustained efforts over a number of decades by Member States, the WHO Secretariat and partners, many countries are still facing multiple challenges in ensuring the availability, affordability, quality assurance and rational use of children's medicines;

PP8 Acknowledging Goal 3 of the 2030 Agenda for Sustainable Development, "Ensure healthy lives and promote well-being for all at all ages" particularly noting the targets related to access to medicines, and its interlinked goals and targets;

PP9 Noting that the WHO World Health Report 2010 identified the promotion of generic medicines as a key action that could be taken to improve access by making medicines more affordable and recognizing the importance of accelerating generic availability and uptake following the expiration of patents;

PP10 Recalling the Convention on the Rights of the Child in which States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illnesses and rehabilitation of health,

(OP1) URGES Member States:²

(1) to accelerate implementation of the actions laid out in resolution WHA60.20 on better medicines for children and WHA67.20 on regulatory system strengthening for medical products;³

(2) to learn from successful experiences with medicines policies for children in other countries and formulate and implement appropriate national measures including legislation as appropriate, and pharmaceutical policies in support of access to quality, safe, effective and affordable medicines for children;

(3) to take all necessary measures, including legislation as appropriate for establishment of national plans and organizational structures and capacity to enhance

¹ Document EB138/41.

² And, regional economic integration organizations, as appropriate.

³ Taking into account the context of federated states.

such measures in the framework of national pharmaceutical policies as appropriate, to improve children's health;

(4) to ensure that national health policies and plans incorporate consideration of the needs of children based on the national situation, with clear objectives for increasing access to children's medicines;

(5) to establish transparent and evidence-based processes for the designing and updating of their national essential medicines list or its equivalent to include medicines for children, according to each country's health needs and priorities, taking into account the WHO model list of essential medicines, including the WHO model list of essential medicines for children, and its transparent and evidence-based process which considers public health relevance, evidence on efficacy and safety and comparative cost-effectiveness;

(6) to implement actions agreed under Sustainable Development Goal 3, with a focus on children, which states: Support the research and development of vaccines and medicines for the communicable and noncommunicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use to the full the provisions in the Agreement on Trade Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health and, in particular, provide access to medicines for all;

(7) to undertake analysis of their pharmaceutical supply systems, including through the use of the WHO standardized surveys, to identify inefficiencies in the cost and pricing structures of medicines and sources of mark-ups on the prices of medicines, and to seek to reduce the price of children's medicines by promoting greater availability and use of generics, and identifying strategies to reduce prices including mark-ups on medicines, in order to increase availability and affordability of medicines for children;

(8) to strengthen research and development of appropriate medicines for diseases that affect children, to ensure that high quality clinical trials for these medicines are conducted in an ethical manner and to collaborate in order to facilitate innovative research and development on, formulation of, and timely regulatory approval of, provision of adequate and prompt information on, and rational use of, medicines for children, including generic medicines;

(9) to facilitate clinical trials of medicines for children based on sound ethics, needs, principles of patient protection, [and to promote clinical trial registration in registries recognized by the WHO international clinical trials registration platform (ICTRP)] and to make information on those trials publically available, including publication of summary and complete data of completed trials in accordance with national and regional legislative frameworks as appropriate;

(10) to strengthen national regulatory systems including pharmacovigilance and post-market surveillance and to promote quality, ethical clinical trials of medicines for children and the accessibility and availability of quality, safe, effective and affordable medicines for children;

(11) to enhance the health workforce education and training in rational use of medicines for children, including generic medicines, and to enhance the health education of the public, to ensure acceptance and understanding of rational use of medicines for children;

(OP2) REQUESTS the Director-General:

(1) to accelerate implementation of the actions laid out in resolutions WHA60.20 on better medicines for children, WHA67.22 on access to essential medicines and WHA67.20 on regulatory system strengthening for medical products;

- (2) to further develop and maintain within the Model List of Essential Medicines, the list of Essential Medicines for Children (EMLc) using evidence-based clinical guidelines in coordination with all relevant WHO programmes;
- (3) to consider appropriate representation of paediatric experts on the WHO Expert Committee on Selection and Use of Essential Medicines;
- (4) to support Member States in taking appropriate measures through provision of training and strengthening regulatory capacity according to national and regional circumstances, and in promoting communication and coordination between countries on paediatric clinical trial design, ethical approval and product formulation, including through regulatory networks;
- (5) to continue to collaborate with governments,¹ other organizations of the United Nations system, including WTO and WIPO, donor agencies, nongovernmental organizations and the pharmaceutical industry in order to encourage fair trade in safe and effective medicines for children and adequate financing for securing better access to medicines for children;
- (6) to support Member States in implementing, as appropriate, upon request, standards for ethical and appropriate clinical trials of medicines in children, and to facilitate communication and coordination among Member States¹ to promote the sharing of paediatric clinical trial information;
- (7) to support analysis and better understanding of costs of research and development for medicines of children, including for rare diseases in children;
- (8) to support countries in implementing relevant policies in line with the 2030 Agenda for Sustainable Development including Goal 3 and related access to medicine targets, and to provide necessary technical assistance in this regard upon request;
- (9) to report to the Seventy-first World Health Assembly on progress in the implementation of this resolution.

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

Resolution: Promoting innovation and access to quality, safe, efficacious and affordable medicines for children	
A. Link to the general programme of work and the programme budget	
1. Please indicate to which impact and outcome in the Twelfth General Programme of Work, 2014–2019 and which output in the Programme budget 2016–2017 this draft resolution will contribute if adopted.	Twelfth General Programme of Work: outcomes 3 and 4.3.1.
2. If there is no link to the results as indicated in the Twelfth General Programme of Work, 2014–2019 and the Programme budget 2016–2017, please provide a justification for giving consideration to the draft resolution.	Not applicable.

¹ And, regional economic integration organizations, as appropriate.

3. What is the proposed timeline for implementation of this resolution?

From the fourth quarter of 2016 until the end of 2019.

If the timeline stretches to future programme budgets, please ensure that further information is provided in the costing section.

B. Budgetary implications of implementation of the resolution**1. Current biennium: estimated budgetary requirements, in US\$ million**

Level	Staff	Activities	Total
Country offices	0.83	0.13	0.96
Regional offices	0.83	0.27	1.10
Headquarters	1.12	0.98	2.10
Total	2.78	1.38	4.16

1(a) Is the estimated budget requirement in respect of implementation of the resolution fully included within the current programme budget? (Yes/No)

Yes.

1(b) Financing implications for the budget in the current biennium:

– How much is financed in the current biennium?

– What are the gaps?

US\$ 4.16 million.

– What action is proposed to close these gaps?

The gap will be addressed through the coordinated resource mobilization efforts for possible financing by voluntary contribution.

2. Next biennium: estimated budgetary requirements, in US\$ million

Level	Staff	Activities	Total
Country offices	0.83	0.123	0.96
Regional offices	0.83	0.27	1.10
Headquarters	1.12	0.98	2.10
Total	2.78	1.38	4.16

2(a) Financing implications for the budget in the next biennium:

– How much is currently financed in the next biennium?

– What are the financing gaps?

US\$ 4.16 million.

– What action is proposed to close these gaps?

The gap will be addressed through the coordinated resource mobilization efforts for possible financing by voluntary contribution.

The second draft resolution, on addressing the global shortage of medicines, had been proposed by the delegations of Kenya, South Africa and the United States of America and read:

The Sixty-ninth World Health Assembly,

PP1 Having considered the report on global shortages of medicines and the safety and accessibility of children's medicines;

PP2 Recommends to the Sixty-ninth World Health Assembly the adoption of the following resolution;

PP3 Recalling the World Health Assembly resolutions WHA67.22 on access to essential medicines, WHA60.20 on better medicines for children, WHA67.20 on Regulatory system strengthening WHA67.21 access to biotherapeutic products, including similar biotherapeutic products, and ensuring their quality, safety and efficacy, WHA61.21 on global strategy and plan of action on public health, innovation and intellectual property, WHA65.19 on substandard/spurious/falsely-labelled/falsified/counterfeit (SSFFC) medical products, WHA65.17 on vaccines, WHA68.7 and WHA67.25 on antimicrobial resistance as well as resolutions WHA64.9 sustainable health financing structures and universal coverage, and also, recalling the Resolution A/HRC/RES/12/24 from the Human Rights Council on access to medicines;

PP4 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 [reference (A67/81)];

PP5 Recognizing that the continuous supply of quality, safe, effective medicines is one of the building blocks of every well-functioning health system, which requires a reliable supply chain: and noting reports of global medicines shortages and stock-outs that also infringe on patients right to health; undermine public health prevention and treatment goals; and threaten governments' ability to scale up services towards achieving universal health coverage;

PP6 Recalling the Agenda 2030 for Sustainable Development, which includes, inter alia, the commitment to achieve universal health coverage, financial risk protection, access to primary health-care services and access to safe, effective, quality and affordable medicines and vaccines for all by 2030;

PP7 Acknowledging that Agenda 2030, supports the research and development of vaccines and medicines for the communicable and noncommunicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, (A/RES/70/1 target 3.b);

PP8 Noting that the challenges related to medicine shortages and stock-outs are widespread, affecting medicine manufacturers, procurement agencies and countries at every economic level, and they appear to be escalating in severity, and the factors that affect the non-availability of medicines can be categorized into three areas: problems with the manufacture of the medicine, challenges with the procurement of medicines and problems with the supply chain which result in medicines being unavailable when patients access care; therefore interventions to address weaknesses in all three areas are critical to ensure that medicines are available at the point of care;

PP9 Aware that the shortage of medicines is a global problem, 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;

PP10 Noting also that the implications of these shortages in the case of infectious diseases goes beyond the individual patient and impacts public health as a shortage/stock-out of antibiotics, antituberculosis drugs, antiretrovirals or vaccines may result in the spread of infection beyond the individual patient;

PP11 Considering that there is a need for improved international collaboration on the management of shortages of medicines given that medicines shortages may increase risks of SSFFC medical products entering the supply chain;

PP12 Concerned about the challenges that shortages of medicines pose to Member States, in relation to ensuring universal access to healthcare, research and development, rational use of medicines, and that the financial sustainability of health systems can be affected by technological pressure caused by high-cost medicines; and aware that urgent patient-centred action is needed by the international community, Member States and relevant actors in health systems,

1. **URGES** Member States:¹

(OP1) to develop strategies that may be used to forecast, avert or reduce shortages, adapted to national priorities and contexts, including:

- (a) to implement effective notification systems that allow remedial intervention to circumvent medicine shortages;
- (b) to ensure that best practices for medicines procurement, distribution and contract management processes are in place to mitigate the risk of shortages;
- (c) to develop systems that are capable of monitoring medicine supply, demand, availability and alerting procurement departments to possible medicine availability problems;
- (d) to strengthen institutional capacity to ensure sound financial management of procurement systems, to prevent funding shortfalls for medicines;
- (e) to promote, review and strengthen programmes, public policies, regulatory frameworks, systems and authorities that promote access to medicines and align policy frameworks to be responsive to medicines that are at risk of being unavailable at the point of care, through the appropriate regulatory strategies;
- (f) to urge Member States to focus on health rights of everyone especially vulnerable groups and to ensure these groups have timely access to medicines in shortage;
- (g) to seek to make medicines more affordable through the implementation of various strategies to manage prices such as price negotiations/regulation, voluntary/compulsory licences in order to decrease prices of medicines in shortage;

(OP2) calls upon manufacturers (active pharmaceutical ingredient and formulation), wholesalers, global, and regional procurement agencies and other relevant stakeholders to contribute to global efforts to address the challenges of medicines shortages, including through participation in notification systems;

(OP3) to advance gradually regional and international integration of national notification systems including but not limited to sharing of best practices, training for human capacity building where necessary with a view of establishing an international notification system for essential medicine shortages and stock-outs;

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

- (1) to support Member States in addressing the global challenges of medicines shortages by developing a global medicine shortage notification system; which may include information to better detect and understand the causes of medicines shortages;
- (2) to propose global best practices for the notification and management of shortages, including data standards, database management and regulatory/legislative strategies including the full use of TRIPS to minimize the impact of shortages;

¹ And, regional economic integration organizations, as appropriate.

- (3) to develop an assessment of the magnitude and nature of the problem of shortages of medicines, including factors such as: market supply system failures and pressures, manufacturing and distribution challenges, and recommended solutions, to address the most important factors identified;
- (4) to identify medicines that are at particular risk of being in short supply and develop strategies to ensure their availability at an affordable price in collaboration with global partners;
- (5) to prioritize, the development of new or updated procurement and supply chain guidelines, to support the effective functioning of health systems and minimize the risk of shortages;
- (6) to work with global partners to strengthen systems for supply chain management;
- (7) to support Member States in the implementation of surveillance systems that will monitor and report supply and demand of medicines, using standardized formats throughout the supply chain, to predict needs and shortages, and that also reduce the risk of SSFFC entering the supply chain;
- (8) to continue to support the Member State mechanism on SSFFC medical products;
- (9) to report on progress and outcome of the implementation of this resolution to the Seventy-first World Health Assembly.

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

Resolution: Addressing the global shortages of medicines	
A. Link to the general programme of work and the programme budget	
1. Please indicate to which impact and outcome in the Twelfth General Programme of Work, 2014–2019 and which output in the Programme budget 2016–2017 this draft resolution will contribute if adopted.	Twelfth General Programme of Work: Outcomes 3 and 4.3.1.
2. If there is no link to the results as indicated in the Twelfth General Programme of Work, 2014–2019 and the Programme budget 2016–2017, please provide a justification for giving consideration to the draft resolution.	Not applicable.
3. What is the proposed timeline for implementation of this resolution?	From the fourth quarter of 2016 until the end of 2019.
<i>If the timeline stretches to future programme budgets, please ensure that further information is provided in the costing section.</i>	

B. Budgetary implications of implementation of the resolution			
1. Current biennium: estimated budgetary requirements, in US\$ million			
Level	Staff	Activities	Total
Country offices	0.20	0.46	0.66
Regional offices	0.16	0.43	0.59
Headquarters	0.55	2.51	3.06
Total	0.91	3.40	4.31
1(a) Is the estimated budget requirement in respect of implementation of the resolution fully included within the current programme budget? (Yes/No)			
Yes.			
1(b) Financing implications for the budget in the current biennium:			
– How much is financed in the current biennium? 0			
– What are the gaps? US\$ 4.31 million.			
– What action is proposed to close these gaps? The gap will be addressed through the coordinated resource mobilization efforts for possible financing by voluntary contribution.			
2. Next biennium: estimated budgetary requirements, in US\$ million			
Level	Staff	Activities	Total
Country offices	0.20	0.46	0.66
Regional offices	0.16	0.43	0.59
Headquarters	0.55	1.51	2.06
Total	0.91	2.40	3.31
2(a) Financing implications for the budget in the next biennium:			
– How much is currently financed in the next biennium?			
– What are the financing gaps? US\$ 3.31 million.			
– What action is proposed to close these gaps? The gap will be addressed through the coordinated resource mobilization efforts for possible financing by voluntary contribution.			

The representative of CHINA said that, after additional consultations, consensus had been reached on subparagraph 1(9) of the first draft resolution. The bracketed text, which read “and to promote clinical trial registration in registries recognized by WHO international clinical trials registration platform” should be replaced by “and to promote clinical trial registration in any registry that provides data to the WHO international clinical trials registration platform”.

The representative of SRI LANKA, noting that the safety and accessibility of medicines was a major challenge in his country, said that a global approach was needed to prevent global shortages and

ensure the safety and accessibility of children's medications. It was necessary to establish a pricing mechanism and a centralized negotiating system that would prevent shortages of essential medicines. Drug registration authorities should give priority to controlling monopolies and oligopolies in the sector.

The representative of NORWAY said that shortages of essential medicines and access to high quality products for children continued to be key priorities for Norwegian development assistance. Her Government had worked to improve access to life-saving commodities by ensuring affordable prices, addressing supply chain and regulatory bottlenecks, and incentivizing local manufacturing. Addressing shortages would require intersectoral partnerships and transparent sharing of information. Monitoring and notification systems were needed to promote early detection of shortages and the identification of joint rapid responses, which would improve national forecasting. Information-sharing on the use of children's medications also needed strengthening. The harmonization of regulations and procurement practices could lead to efficiencies and should be promoted. Ensuring adequate paediatric formulations and vaccines and medicines for epidemic outbreaks would require joint effort with the private sector. She supported both draft resolutions.

The representative of INDONESIA said her Government had a special scheme in place to ensure access to medicines; however, it could not do so effectively when global shortages occurred. She agreed that options to prevent and manage global stock-outs should involve drug regulators, health care professionals, ministries of finance, pharmaceutical manufacturers and other related agencies and institutions. She urged the Secretariat to move forward with developing a globalized notification system and response mechanism to prevent and manage shortages and stock-outs. It was to be hoped that the first draft resolution would lead to substantive improvement and pragmatic action to enhance the safety and accessibility of children's medication.

The representative of IRAQ said that WHO had a role to play in supervising pharmaceutical companies in order to ensure an equitable and needs-based distribution of medicines and vaccines. Specific medicines, such as paediatric medication and medicines for cancer and other noncommunicable diseases should be supervised and sponsored by WHO to ensure their availability. The Secretariat should also promote capacity-building for personnel and institutions in relation to medicines policy, procurement management and drug registration. Vulnerable groups such as mothers and children should be given priority in the provision of essential medicines and vaccines.

The representative of FINLAND said that increased research and development was needed on diseases specifically affecting children for which no paediatric medication was available. It was important to develop formulations that could be used where there was no cold chain or access to clean water. Clinical trials in children must adhere strictly to the highest ethical standards at all times. Increased transparency with respect to the results of clinical trials was crucial to enhance collective knowledge and reduce unnecessary testing. He called on the Secretariat to provide guidance in that regard. Where relevant, applications for the inclusion of medicines on the WHO Model List of Essential Medicines should be required to include data on paediatric use. An expert group should be set up to assess such applications. The experts could also advise the Secretariat on gaps in access to paediatric medicines that required urgent attention. He supported the draft resolution on promoting innovation and access to medicines for children and, in particular, endorsed the request that the Director-General should increase the number of specialists in paediatric medicine on the WHO Expert Committee on Selection and Use of Essential Medicines.

The representative of ARGENTINA said that any strategy that used higher prices as an incentive to pharmaceutical companies and as a means of reducing the risk of shortages of essential medicines could prove counterproductive, as some medicines could become unaffordable. Shortages

could lead to inappropriate use of medicines, putting patient safety at risk. States should strengthen their capacity to assess the cost-effectiveness of high-cost technologies.

The representative of the UNITED REPUBLIC OF TANZANIA said that his country had faced the challenges outlined in the report and fully supported the options for action proposed therein, especially in relation to medicines for children. He supported the adoption of both draft resolutions.

The representative of the BOLIVARIAN REPUBLIC OF VENEZUELA, speaking on behalf of the Members of the Union of South American Nations, said that ensuring equitable access to medicines was a prerequisite for the achievement of universal health coverage. Shortage and stock-outs of medicines was a global problem requiring attention by the Health Assembly, which should take action to address, with the Secretariat's support, barriers to access, especially for children, who should not be deprived of access to medicines owing to shortages of paediatric formulations. The Member States of the Union of South American Nations had agreed in 2014 to strengthen regional monitoring mechanisms in order to generate information and early alerts with a view to preventing shortages. He urged the Secretariat and Member States to promote the development and use of best practices for preventing and managing shortages and to work together to improve equitable access to medicines.

The representative of TUNISIA expressed support for the proposals put forward in the report to prevent and manage shortages of essential medicines. She particularly welcomed the idea of establishing a global list of essential medicines in short supply or susceptible to shortages. WHO should consider establishing international agreements with pharmaceutical companies in order to ensure the availability of essential medicines. Her country had worked closely with WHO to formulate legislation and put in place mechanisms to ensure the availability of safe, high quality and effective medicines and now produced half of its pharmaceutical requirements. In addition, Tunisia had set up a national observatory to monitor and ensure adequate supplies of essential medicines.

The representative of JAPAN said that it was important to collect and evaluate scientific data on the effectiveness and safety of medicines for children and to provide that information to health care providers. His Government had adopted various measures to promote the clinical development of children's medications and would be happy to share its experience with others. He urged other Member States also to share best practices in procurement and supply management. Although shortages of essential medicines were often regarded as a problem of countries with limited resources, all countries faced shortages. He therefore encouraged the Secretariat to develop concrete measures that were applicable to all countries, regardless of level of economic development. He welcomed the two draft resolutions.

The representative of GABON, speaking on behalf of the Member States of the African Region, said that shortages of essential medicines were caused by various factors, including difficulties in obtaining raw materials, high prices, fragmentation of markets and lack of local producers. Access to paediatric medicines, in particular, was hindered by lack of regulatory mechanisms to ensure the quality of medicines and poor representation of children in clinical trials. Those challenges could best be met through the use of online information systems, improved coordination among producers and approval and local production of generic medicines. Better international coordination and the creation of a global evaluation system and a global supply management mechanism would facilitate early detection of and rapid response to shortages. Attention to pricing practices was also needed. Member States in the Region fully supported the strategies developed following the adoption of resolution WHA60.20 (2007) on better medicines for children, including the Paediatric Medicines Regulators Network, and considered it important to mobilize resources to ensure the sustainability of those efforts. They also supported the two draft resolutions.

The representative of the REPUBLIC OF KOREA said that, in order for an international notification system to operate effectively, the terms “stock-outs” and “shortages” should be clearly defined; the former meant that a medicine was no longer in stock, and the latter meant that there was not enough to meet demand. A global information-sharing mechanism should be created to enable Member States to report shortages of essential medicines in a timely manner. Global and regional working groups should be established in order to enhance cooperation between countries and ensure a stable supply chain. Her country wished to be added to the list of sponsors of the draft resolution addressing the global shortage of medicines.

The representative of ETHIOPIA welcomed the Secretariat’s work, including the WHO Model List of Essential Medicines for Children and the development of global standards for the formulation of paediatric medicines. His Government had adopted various strategies to facilitate the registration of medicines suitable for children, including streamlined review of documentation on WHO prequalified medicines and permitting clinical trials for paediatric medicines in special circumstances. It was committed to working in partnership with the pharmaceutical industry to encourage the reformulation of paediatric medicines for regulatory submission and with the Paediatric Medicines Regulators Network to develop legislation relating to medicines for children.

The representative of the UNITED KINGDOM OF GREAT BRITAIN AND NORTHERN IRELAND, endorsing the draft resolution on medicines for children, said that a more coordinated approach that tackled persistent drivers of shortages and stock-outs was needed. Her Government had worked with partners such as the Global Fund to Fight AIDS, Tuberculosis and Malaria, the GAVI Alliance and UNITAID to increase access to medicines, including paediatric antiretroviral medicines, and to explore innovative approaches to intellectual property issues, such as patent pooling and market-shaping programmes.

Referring to the progress report on access to essential medicines (document A69/43, part G), she said that WHO should continue to take a coordinated systems approach, integrating efforts with overall health system strengthening and ensuring data-sharing across all initiatives relating to access to medicines. She encouraged Member States to ensure adequate funding for that work.

The representative of ITALY said that more action should be taken to ensure the availability of adequate supplies of medicines for persons with chronic and infectious diseases, in particular tuberculosis and HIV disease. Ensuring children’s access to medicines for tuberculosis prevention and control was especially important. The Secretariat should promote global and local partnerships of governments, pharmaceutical companies, regulators and civil society organizations with a view to establishing monitoring, evaluation and accountability systems and joint procurement schemes. Steps should also be taken to overcome market barriers and provide appropriate technical support to countries on registration of medicines. Without rapid uptake of new formulations, there was a risk that their production would cease. He therefore called for additional investment in research on paediatric formulations. His country wished to be added to the list of sponsors of the draft resolution on medicines for children.

The representative of COSTA RICA, noting the importance of reaching an international agreement to ensure continuity in the manufacture and supply of essential medicines, said that a means should be found of ensuring international access to the results of studies and clinical trials on paediatric medicines, especially for medicines designed to treat complex and rare diseases in children.

The representative of SENEGAL said that a global regulatory system would help to ensure the availability of essential medicines. Ideally, each medicine should be available from at least three producers. Supply coordination systems and streamlining of procurement and marketing authorization procedures for essential medicines could help to ensure a constant supply of medicines. The WHO Model List of Essential Medicines for Children should be more widely publicized, particularly among

low-income countries, and it should be ensured that each country had a mechanism to enable it to procure paediatric medicines without major constraints. He supported the draft resolution on medicines for children.

The representative of PANAMA said that her Government had taken measures nationally to tackle shortages of essential medicines, including the introduction of domestic legislation to assure the quality and safety of medicines and the strengthening of the National Medicines Commission. Pooled-procurement mechanisms, such as those available through PAHO and UNICEF, provided a useful means of improving the availability and affordability of essential paediatric medicines. She supported both draft resolutions.

The representative of THAILAND, expressing support for the draft resolution on medicines for children, emphasized the importance of disseminating the results of clinical trials in order to promote transparency and avoid duplicating studies and wasting resources. She supported the draft resolution on global shortages of medicines, but if permitted would like to propose some amendments to strengthen it.

The representative of SOUTH AFRICA said that solving the complex problem of medicines shortages and stock-outs would require in-depth understanding; there was no single solution. The unavailability of first-line medicines for the treatment of infectious diseases could result in widespread use of second-line medicines intended for restricted use, contributing to antimicrobial resistance, with significant consequences for public health. He supported the proposals put forward in the draft resolution on medicines shortages, particularly global collaborative responses, an international notification system and in-country surveillance systems. He proposed that a revised version of the draft resolution on shortages of medicines, incorporating several suggested amendments, be circulated in due course.

The representative of COLOMBIA said that his Government had been adopting innovative measures to ensure access to medicines, including strengthened technology assessment processes and price regulation. Access to and availability of efficacious, safe and affordable medicines was a prerequisite for the enjoyment of the right to health. His country wished to be added to the list of sponsors of the draft resolution on medicines for children.

The observer of CHINESE TAIPEI said that Chinese Taipei had a health insurance system that covered the cost of more than 15 000 medicines, an online platform for reporting of shortages of medicines, and a strategic plan for preventing and mitigating those shortages. More than 80% of shortages had been mitigated as a result. Incentives such as increased reimbursement and lower prices for new paediatric formulations and dosage forms had helped to encourage the introduction of innovative medicines for children.

The representative of the INTERNATIONAL PHARMACEUTICAL FEDERATION, speaking at the invitation of the CHAIRMAN, welcomed the timely report, as existing shortages were worsening and new shortages were occurring; in the Bolivarian Republic of Venezuela, for example, 75% of medicines were unavailable. A coordinated international approach involving all stakeholders was needed to ensure continuity in the supply of medicines. It was gratifying to see reflected in the report a series of recommendations that had been agreed by a broad range of stakeholders at an event her organization had hosted in Canada in 2013. Pharmacists were committed to finding solutions to ensure timely access to medicines.

The representative of the BOLIVARIAN REPUBLIC OF VENEZUELA said that it was regrettable that, in the context of the Health Assembly, irresponsible references were being made to figures relating to the situation in his country. The source of the figure cited was unknown. Moreover,

although there were stock-outs of medicines in his country, they were by no means as severe as had been suggested, and the problem was confined to specific types of medicines for the treatment of certain types of diseases, a problem that was linked to what was known as the “economic war” in his country. His Government was committed to ensuring access to medicines for the entire population and had put in place an essential medicines policy and a pharmacy network. Anybody who had difficulties finding medicines could call a free national hotline.

The representative of MÉDECINS SANS FRONTIÈRES INTERNATIONAL, speaking at the invitation of the CHAIRMAN, said that the problem of shortages and stock-outs of medicines needed long-term structural solutions, including measures to address market failures, monopolies and supply-chain weaknesses. Uncoordinated changes in treatment guidelines could increase the risk of stock-outs. Common definitions of shortages and stock-outs were necessary, as were indicators to measure the number of patients who received the right amount of the correct medicine. Patient should be involved in reporting whether medicines arrived. That information would assist in forecasting and help to prevent shortages.

The representative of the INTERNATIONAL FEDERATION OF MEDICAL STUDENTS' ASSOCIATIONS, speaking at the invitation of the CHAIRMAN, said that the current research and development system was incapable of providing effective solutions to medicines shortages. Patents no longer encouraged innovation or the development of new medicines, and alternative models were therefore needed. Innovative incentives for research and development at every stage of the process were imperative to address inequalities in access to medicines throughout the world. WHO should speak out against international trade agreements currently under negotiation that had the potential to negatively impact access to medicines.

The representative of the GLOBAL HEALTH COUNCIL, speaking at the invitation of the CHAIRMAN, supported the new requirement to include paediatric data in applications for inclusion of medicines relevant to children in the WHO Model List of Essential Medicines. All applications for the inclusion of new medicines or for changes to or deletions from that List should also be evaluated for the WHO Model List of Essential Medicines for Children. The continued lack of paediatric formulations of antiretroviral medicines led to irregular treatment adherence and high rates of treatment failure. The development of fixed-dose combinations and other paediatric formulations was urgently needed. As many noncommunicable diseases could not be diagnosed or managed without basic medical technologies, she encouraged coordinated efforts to include essential medicines and basic technologies for noncommunicable diseases in work designed to tackle shortages and stock-outs of medical supplies.

The representative of the INTERNATIONAL PHARMACEUTICAL STUDENTS' FEDERATION, speaking at the invitation of the CHAIRMAN, said that real-time reporting systems that informed all relevant stakeholders of disruptions in medical supplies would enable pharmacists to make informed clinical decisions. Through medication substitution, cost-effective procurement and equitable medication allocation pharmacists could mitigate the potential harm to patients caused by gaps in supply. She encouraged Member States that had not yet implemented real-time systems to do so without delay and called on WHO as a whole to take account of pharmacy practice when considering solutions to the problem of medicines shortages.

The representative of the WORLD HEART FEDERATION, speaking at the invitation of the CHAIRMAN, particularly welcomed the reference in the report to shortages of benzathine penicillin G, a medicine that was crucial to the prevention of rheumatic heart disease, a preventable disease that began in childhood. High-quality supplies of benzathine penicillin G could be secured by collating and sharing national data on the need for it, enhancing manufacturing capacity by working with the pharmaceutical industry and encouraging countries with a high burden of rheumatic heart disease to

include benzathine penicillin G in their national essential medicines list. Action was also needed to improve the availability of some essential medicines for cardiovascular disease, including cheap, generic, widely-manufactured products such as aspirin.

The representative of the UNION FOR INTERNATIONAL CANCER CONTROL, speaking at the invitation of the CHAIRMAN, welcomed the inclusion of 46 cancer medicines in the 2015 update of the WHO Model List of Essential Medicines. Shortages of essential medicines to treat cancer resulted in children with curable cancers dying unnecessarily in many parts of the world. She approved the focus in the report on strengthening regulatory infrastructures in order to tackle weak distribution chains, poor storage and counterfeit medicines. Efforts to stabilize demand and identify incentives for manufacturers to enter the children's medicines market were also to be encouraged. She also welcomed the emphasis on overall health system strengthening in the two draft resolutions.

The representative of HEALTH ACTION INTERNATIONAL, speaking at the invitation of the CHAIRMAN, said that essential medicines could be made accessible and affordable by removal of barriers to their import and of mark-ups on generic medicines, in particular those for noncommunicable diseases. The global market for many paediatric medicines was characterized by low and inconsistent demand, erratic production and volatile prices, which led to poor access to essential medicines and the preventable deaths of thousands of children each year. Member States should consider developing regional pooled financing and procurement mechanisms, such as PAHO's Revolving Fund. Such mechanisms would aggregate demand, resources and procurement power and help to stabilize the production, prices and quality of medicines.

The ASSISTANT DIRECTOR-GENERAL (Health Systems and Innovation) recalled that shortages and stock-outs of medicines had been increasing throughout the world, affecting all Member States, for complex reasons. The commitment expressed in the draft resolution on shortages of medicines to timely, joint action was important. The Secretariat acknowledged the need to strengthen international cooperation with all stakeholders and to support information-sharing. Monitoring the availability of medicines across regions would be especially important, as would the development of a list of key medicines that were in short supply. Terms and definitions must also be standardized.

With regard to medicines for children, the Secretariat commended the efforts of Member States to accelerate the actions laid out in resolution WHA60.20 (2007) on better medicines for children and resolution WHA67.22 (2014) on access to essential medicines. The Secretariat would intensify its support to Member States for those efforts. The international community needed to do more to improve access to medicines for children, including action to ensure fair and affordable prices. She had taken note of the comments on the need: to increase expertise in the work on the WHO Model List of Essential Medicines for Children; to promote global standards on the formulation of medicines for children; and to ensure the availability of medicines for children with tuberculosis. She acknowledged the importance of supporting the optimization of procurement mechanisms for children's medicines, including through existing global mechanisms.

The Committee noted the report.

The CHAIRMAN invited the Committee to consider the draft resolution on promoting innovation and access to quality, safe, efficacious and affordable medicines for children.

The representative of CHINA said that, as agreed, the bracketed text in paragraph 1(9) would be amended to read: "and to promote clinical trial registration in any registry that provides data to the WHO international clinical trials registration platform (ICTRP)". A footnote would also be added after "registry", reading: "including internationally-recognized open registries such as clinicaltrials.gov, among others, and national registries".

The draft resolution, as amended, was approved.¹

The CHAIRMAN suggested that consideration of the draft resolution on addressing the global shortage of medicines should be deferred to allow for further consultations.

It was so agreed.

(For continuation of the discussion and approval of the draft resolution, see the summary record of the seventh meeting, section 4.)

The meeting rose at 17:40.

¹ Transmitted to the Health Assembly in the Committee's third report and adopted as resolution WHA69.20.

SIXTH MEETING

Saturday, 28 May 2016, at 09:40

Chairman: Dr PHUSIT PRAKONGSAI (Thailand)

1. COMMUNICABLE DISEASES: Item 15 of the agenda [transferred from Committee A]

Mycetoma: Item 15.3 of the agenda (documents A69/35 and EB138/2016/REC/1, resolution EB138.R1)

The representative of SOUTH AFRICA, speaking in her capacity as Chairman of the Executive Board, said that, during the Board's consideration of the report on mycetoma at its 138th session, the proposed draft resolution had been amended so as to request WHO, through the Strategic and Technical Advisory Group for Neglected Tropical Diseases, to define a process for the evaluation of, and inclusion of additional diseases in, the list of neglected tropical diseases.¹ Subsequently (Geneva, 12 and 13 April 2016), that Advisory Group met and finalized recommendations for the adoption of additional diseases as neglected tropical diseases.²

The representative of NIGER, speaking on behalf of the Member States of the African Region, recalled that, at the Sixty-eighth World Health Assembly, proposals had been made to include mycetoma in the list of neglected tropical diseases prioritized by WHO. Noting the information in the report, including the measures taken to address mycetoma, she said that the African Region strongly supported the work of the Mycetoma Research Center in Khartoum to promote the development of tools and strategies to combat the disease. She called on Member States to support the draft resolution and to ensure its effective implementation.

The representative of SUDAN, expressing gratitude that mycetoma was being considered for inclusion in the list of neglected tropical diseases, drew attention to the stigmatization suffered by patients affected by the disease who often had low socioeconomic status and lived in remote communities. He called on the Health Assembly to adopt the draft resolution in order to improve the quality of life of people living with mycetoma, narrow the knowledge gap on the disease and establish clear procedures for patient care.

The representative of SAUDI ARABIA said that insufficient attention had been given to research and development on mycetoma owing to lack of resources and the stigmatization associated with the disease. He recommended the adoption of the draft resolution, which would draw greater resources and raise awareness to the problem.

The representative of KENYA said that, although mycetoma was not considered to be endemic in Kenya, his country was nevertheless at risk as it had a significant area within the so-called "mycetoma belt", experienced environmental conditions favouring the disease, and bordered Sudan where the disease was endemic. As including mycetoma in the list of neglected tropical diseases was the only means of attracting the attention of donors and pharmaceutical companies, which should

¹ See paragraph 3(6) of resolution EB138.R1.

² http://www.who.int/neglected_diseases/events/ninth_stag/en/ (accessed 19 July 2016).

result in more effective prevention and control programmes, he supported adoption of the draft resolution.

The representative of IRAQ, speaking on behalf of the Member States of the Eastern Mediterranean Region, observed that, although the mycetoma belt covered countries in four WHO regions, mycetoma might also be a silent disease in other countries. Action was needed to raise awareness in affected communities and those potentially at risk, and more data were needed on the epidemiological and global burden of the disease. Treatment regimens, especially for fungal mycetoma, must be improved. Including the disease in the list of neglected tropical diseases would encourage partners to develop better diagnostic tools and medicines to ensure that communities were not left behind. He therefore supported the draft resolution.

The representative of the REPUBLIC OF KOREA observed that several poverty-related diseases in tropical regions were still being neglected and he supported WHO's efforts to improve its surveillance and management system for the prevention and control of mycetoma.

The representative of JAPAN expressed support for the draft resolution. Because the list of neglected tropical diseases entailed focused action and clear procedures were needed for modifying the list, he attached great importance to subparagraph 3(6) of the draft resolution, which called for a clear process of evaluation. He would welcome the addition of mycetoma to the list of neglected tropical diseases. A pharmaceutical company in Japan had begun studies to develop medicines to tackle the disease.

The representative of THAILAND expressed appreciation for the efforts made by WHO and its partners to tackle mycetoma, in particular through the WHO Collaborating Centre on Mycetoma in Khartoum. Noting the challenges that remained, he supported the draft resolution, considering that the inclusion of mycetoma in the list of neglected tropical diseases would accelerate the implementation of prevention and control measures, including health education, personal hygiene and environmental sanitation in affected countries.

The representative of the UNITED STATES OF AMERICA supported the draft resolution and endorsed the remarks by the representative of Japan on subparagraph 3(6), which provided for WHO to develop a set of criteria and a process for decisions about modifying the list of neglected tropical diseases. He underlined the draft resolution's emphasis on effective prevention strategies and tools, such as rapid diagnosis and improved treatments.

The representative of SOUTH AFRICA, stressing that mycetoma was a neglected tropical disease of public health concern, said that he supported the Secretariat's recommendations, which would help countries to determine the disease's prevalence and at-risk groups. The Secretariat should guide countries in conducting analyses and developing sustainable surveillance strategies.

The representative of SWITZERLAND welcomed the implementation of a technical system to evaluate and modify the list of neglected tropical diseases and supported the draft resolution.

The ASSISTANT DIRECTOR-GENERAL (HIV/AIDS, Tuberculosis, Malaria and Neglected Tropical Diseases) said that the Executive Board's discussion on mycetoma had indicated that some tropical diseases continued to be neglected, socially, financially and technically. In the case of mycetoma, prevention measures were not sufficient to make a substantial impact. The adoption of the draft resolution would result in advocacy work by WHO to improve the surveillance and control of mycetoma and the design of tools and strategies to enable health services to manage cases. The discussion had also triggered the development of a systematic technical process to evaluate and

potentially include additional diseases in the list of neglected tropical diseases. WHO would tailor its mandate to address persistent needs and ensure that nobody was left behind.

The draft resolution was approved.¹

Draft global health sector strategies: Item 15.1 of the agenda (documents A69/31, A69/32, A69/33, A69/59 and A69/59 Add.1)

- **HIV, 2016–2021**
- **Viral hepatitis, 2016–2021**
- **Sexually transmitted infections, 2016–2021**

The representative of CHINA supported the priorities and the prevention and control measures outlined in the three draft global strategies. His Government attached great importance to the prevention and control of the diseases concerned and had taken measures to address them in China. The draft strategies must respect differences among Member States, making allowance for the adjustment of indicators and domestic action priorities. HIV and sexually transmitted infections were not only public health issues but also complex social problems, which required multisectoral and multidisciplinary efforts. WHO should enhance its coordinating role to bring about multisectoral cooperation and the participation of society as a whole. It should furthermore increase its provision of technical and financial support to developing countries and use its influence with pharmaceutical companies in the negotiation of lower medicine prices.

The representative of AUSTRALIA, acknowledging that progress remained uneven and inequitable, endorsed the three draft strategies and the draft resolution contained in document A69/59. Common activities across the strategies should be highlighted in order to support Member States in prioritizing actions and leveraging combination interventions, and reporting requirements should be streamlined to reduce the reporting burden. He welcomed the use of universal health coverage as an organizing framework for the three strategies. In particular he recognized the challenge of ensuring affordable access to effective new treatments and encouraged the Secretariat to continue supporting Member States in price negotiations. In that regard, the efforts of the Western Pacific Regional Office to support collective negotiations to increase affordable access to hepatitis C medicines were laudable.

The representative of IRAQ, speaking on behalf of the Member States of the Eastern Mediterranean Region, endorsed the three draft strategies. Although progress had been made in some areas, Member States in the Region continued to face challenges related to poor access to treatment, the affordability of medicines and unsafe practices. The situation had been aggravated by the unprecedented humanitarian crisis in the Region, which hampered national responses; new groups of displaced people had limited access to prevention, diagnosis and treatment services. He called on the Secretariat to support efforts in the Region to adapt policy and service delivery models and to mobilize the necessary investments.

The representative of CABO VERDE, speaking on behalf of the Member States of the African Region, said that, like HIV, tuberculosis and malaria, viral hepatitis was an international public health challenge. Only recently, however, had hepatitis and its huge impact on health and development been given adequate attention. The draft global health sector strategy on viral hepatitis was the first global strategy on that disease and it would help Member States to achieve target 3.3 of the Sustainable

¹ Transmitted to the Health Assembly in the Committee's fourth report and adopted as resolution WHA69.21.

Development Goals. The strategy must, *inter alia*, be used to raise awareness of the importance of combatting hepatitis, and must draw attention to the prohibitively high cost of medicines, especially for developing countries. Member States of the Region supported the draft strategy, which offered a framework for concerted action at the country, regional and global levels. He urged all Member States to provide the necessary resources to ensure universal access to health care services and to uphold and promote human rights, gender equality and equity in health. The Secretariat should, moreover, work with the pharmaceutical industry and other stakeholders in order to reduce the costs of medicines used to treat hepatitis. Member States of the Region would continue to encourage the development of innovative approaches to combat the disease.

The representative of SWITZERLAND, welcoming the consultative process to drafting the three strategies, said that they would facilitate the achievement of target 3.3 of the Sustainable Development Goals and promote the achievement of the broader 2030 Agenda for Sustainable Development. An integrated approach to implementation was needed with a view to enhancing the treatment of HIV disease in primary health care institutions established as part of universal health care systems. The alignment of the draft global health sector strategy on HIV with the UNAIDS 2016–2021 Strategy “On the fast-track to end AIDS” was commendable and would bolster the international community’s shared commitment to eliminating AIDS by 2030. She welcomed the flexibility of the draft strategy, which would allow individual countries to tailor their responses to the epidemic. She supported their adoption.

The representative of ARGENTINA, speaking on behalf of the Member States of the Region of the Americas, said that HIV remained a serious concern in the Region, despite the introduction of legislation and cross-cutting policies. He welcomed the draft global health sector strategy on HIV and its alignment with UNAIDS priorities, goals and targets and with the 2030 Agenda for Sustainable Development. Regional consultations could further efforts to combat HIV, but full implementation and achievement of the goals of the draft strategy would require close cooperation at all levels of the Organization and with Member States. He welcomed the fact that Member States would be able to implement the draft strategy with flexibility and trusted that the United Nations General Assembly High-level Meeting on Ending AIDS due to be held in June 2016 would bolster global commitment to take the steps necessary to eliminate AIDS by 2030. He urged WHO to remain vigilant to the dangers posed by sexually transmitted infections and to take timely action to protect vulnerable populations.

The representative of the UNITED KINGDOM OF GREAT BRITAIN AND NORTHERN IRELAND, supporting the adoption of all three draft strategies, commended the clear focus in the draft global health sector strategy on HIV on comprehensive prevention, integration and health system strengthening and on country investment that prioritized cost-effective interventions for those most in need. The Secretariat must support governments to expand HIV initiatives equitably in order to ensure that the most sick and vulnerable people were not left behind. Furthermore, given the social drivers of HIV infection, a multisectoral approach was required to achieve the goals of the draft strategy on HIV and the UNAIDS 2016–2021 Strategy. He asked for further information on how the Secretariat would support governments’ efforts to ensure that pre-exposure prophylaxis was used safely and effectively.

The draft global health sector strategy on viral hepatitis provided much-needed guidance. To reduce the incidence of undiagnosed viral hepatitis, his country was seeking to offer testing to all those at high risk of infection. It would be difficult for many Member States to meet the draft strategy’s ambitious targets as treatment remained largely unaffordable and it was therefore essential that both prevention and treatment programmes were integrated into their health care systems.

He welcomed the focus of the draft global health sector strategy on sexually transmitted infections on evidence-based interventions, links to other risk-taking behaviour and reducing stigmatization. He strongly supported the milestones for 2020 and the establishment of national surveillance systems to monitor antimicrobial resistance.

The representative of the REPUBLIC OF KOREA welcomed the draft global health sector strategies, which were timely. In order to achieve the objectives of the strategies on HIV of both WHO and UNAIDS, as well as the relevant Sustainable Development Goals, international financial support and global partnerships needed to be expanded. His country would participate in this response effort.

In terms of hepatitis B prevention and control, his country had made significant progress. All pregnant women were screened and birth-dose vaccinations had reduced the prevalence of hepatitis B in children under 5 years of age. The country had recently experienced an outbreak of hepatitis C virus infection associated with health care, and he underscored the importance of following standard precautions and safe injections in order to reduce the risk of such outbreaks.

Vaccination of 12-year-old girls with human papillomavirus vaccine would begin in June 2016 and, through a safer-sex education awareness initiative and advertising campaigns, awareness would be raised among adolescents about the consequences of human papillomavirus infection and other sexually transmitted infections, including HIV, and the importance of screening and treatment.

The representative of AUSTRIA welcomed the draft global health sector strategy on sexually transmitted infections, particularly its emphasis on national immunization programmes to prevent human papillomavirus infection. Austria had a well-established immunization programme that targeted both girls and boys between the ages of 9 and 11 years and free vaccination with quadrivalent human papillomavirus vaccine was offered as part of that programme. Austria's strategy against human papillomavirus infection had proven to be extremely cost-effective, and herd immunity against the virus would soon be reached nationwide.

The representative of JAPAN welcomed the three draft global health sector strategies, but expressed concern that some proposed measures could offend local sensitivities. Consequently, countries must be able to implement them in a flexible manner if they were to achieve optimal health outcomes. Paragraphs 46 and 47 of the draft global health sector strategy on HIV (document A69/31, Annex) and paragraph 2 of the draft resolution (document A69/59) were particular welcome.

Drug resistance, in the treatment of HIV, sexually transmitted infections and, no doubt, soon hepatitis viruses, was a matter of grave concern. Urgent and coordinated action was needed from all relevant stakeholders to minimize the risks that resistance would develop.

Many States no longer required, or were reducing their dependence on, official development assistance, resulting in an increased need for technical assistance from the Secretariat and other agencies, including UNAIDS, in order to help them to convert from donor to domestic financing of their health sector programmes.

The representative of the RUSSIAN FEDERATION welcomed the acknowledgement in the draft resolution on the global health sector strategies (document A69/59) of the importance of taking into account domestic legislation and countries' legal responsibilities, as had been proposed by her delegation at the 138th session of the Executive Board. The draft resolution failed, however, to place enough emphasis on people taking responsibility for their own health, family values and the need to refrain from highly risky forms of behaviour. Such emphasis was crucial if States were to prevent the spread of disease, particularly among young people. The Russian Federation had adopted a national strategy to combat the spread of HIV, which incorporated established best practices and recommendations on HIV control.

She supported the adoption of the draft global health sector strategies.

The representative of TUNISIA said that her country had enhanced its programmes to combat viral hepatitis, for instance through the establishment of a secure digital database that maintained the confidentiality of individuals' medical records, and the launch of a programme to eliminate hepatitis C that made use of data collected during a national survey of hepatitis A, B and C in 2014–2015. That programme also aimed to raise awareness of the disease. Her Government was seeking to reduce the costs of antivirals with a view to ensuring that all infected individuals received treatment. She urged

the Secretariat to support Tunisia's efforts to combat viral hepatitis, and particularly its screening and follow-up programmes.

The representative of TIMOR-LESTE, speaking on behalf of the Member States of the South-East Asia Region, said that the three draft global health sector strategies would bolster efforts to achieve the relevant targets under Sustainable Development Goal 3. Universal health coverage was the main driver for the implementation of the three strategies, which could be delivered through robust primary health care.

The Member States of the Region had made significant progress in controlling the HIV epidemic. Between 2001 and 2014, new HIV infections had declined by 34% and most countries had adopted test-and-treat programmes. They were committed to eliminating AIDS and discrimination against those living with the HIV virus by 2030.

Further investment and concerted efforts were needed to realize the objectives of the three strategies. Countries shifting from external funding must take steps to mobilize and secure domestic funding, and countries that depended on external funding must enhance coordination. The costs of medicines to treat hepatitis C were high, and coherent strategies for the production of low-cost generic medicines in countries with high levels of hepatitis C virus infections were lacking. Stakeholders needed further scientific information so as to formulate effective programmes to combat the spread of human papillomavirus, particularly given the large budgetary implications of such programmes. To that end, the national immunization technical advisory groups should be strengthened to help stakeholders to take evidence-based decisions.

The representative of THAILAND noted that mechanisms to monitor resistance to antiretrovirals were often weak and called on Member States to work with their development partners and the Secretariat to establish effective mechanisms for strengthening them. The Secretariat was ideally placed to coordinate efforts to develop a sorely-needed vaccine against hepatitis C, building on lessons learned in the development of a vaccine against Ebola virus infection. Given their similarities in terms of transmission, the global community must develop a comprehensive screening, diagnosis and treatment package that would empower States to combat HIV, viral hepatitis, and sexually transmitted infections effectively. The draft global strategies must be flexible enough so that States could adapt them to the particular challenges they faced, and the Secretariat should ensure that its recommendations for specific interventions in that regard were firmly evidence-based.

He called on Member States to strengthen their mechanisms for assessing the economic impact of new health technologies, and to work with their development partners, including WHO, to decide which technologies could provide the best value for money and long-term health care outcomes.

The representative of INDONESIA said that his country was committed to stopping transmission of syphilis from mother to child and eliminating HIV and hepatitis B. In collaboration with the Secretariat, Indonesia had convened a regional workshop on viral hepatitis in April 2016, which had recognized that early diagnosis and treatment were crucial and that communities must therefore enjoy access to comprehensive and quality health care services. Support for initiatives to combat viral hepatitis from government, the private sector, including pharmaceutical companies, and local communities was also vital. Moreover, it would prove impossible to eliminate viral hepatitis unless efforts were made to combat discrimination against those with the disease; stigmatization and discrimination must therefore be addressed specifically in culturally-appropriate awareness-raising initiatives.

The representative of CANADA welcomed the reference in the draft global health sector strategy on sexually transmitted infections to controlling the spread and impact of gonococcal antimicrobial resistance; an effective public health response must include the prevention of antimicrobial resistance with a view to maintaining the availability of effective treatments for sexually transmitted infections. She endorsed the focus on harm reduction for people who injected drugs and

the acknowledgement that that was a key component of a comprehensive approach to reducing the prevalence of HIV and hepatitis C. She strongly supported drug policies that were informed by solid scientific evidence and used the lens of public health to maximize education and minimize harm. Addressing the needs of all key populations would help to safeguard their rights, including the right to sexual and reproductive health. She called on the Secretariat to harmonize, as far as was possible, the draft strategy accountability and reporting requirements with Member States' existing obligations.

The representative of GERMANY welcomed the three draft global health strategies and, in particular, the timely introduction of WHO's first draft strategy on viral hepatitis. She called on the Secretariat and Member States to consider the key role of prevention in reducing new infections and treatment costs. Preventive action should be based on country contexts and include comprehensive harm reduction programmes for people who injected drugs, measures to strengthen local health systems, infection control and awareness raising. Further financial and strategic synergies with other international frameworks in the implementation of the strategy might include the strategy of the Global Fund to Fight AIDS, Tuberculosis and Malaria and the UNAIDS 2016–2021 Strategy. Overcoming stigmatization and discrimination in the health sector was crucial for equal access to viral hepatitis services and should therefore be a priority for countries when implementing the strategy.

The representative of MALTA described the situation in her country, noting a recent sharp increase in new HIV infections among men who had sex with men and a considerable rise among foreign residents. A strategy and action plan were in preparation that included specific actions targeting high-risk groups. HIV had been identified as a priority for Malta's Presidency of the Council of the European Union in the first half of 2017. Joint action was needed to find innovative solutions to the persistently high costs of diagnosis, prevention and antiretroviral treatment. She welcomed the draft strategy on HIV and supported its adoption.

The representative of SOUTH AFRICA, noting that there were vaccines against hepatitis A, B and E and that hepatitis C could be cured, expressed concern that hepatitis B was a chronic disease requiring lifelong treatment. It was vital that the cost of treatment of viral hepatitis should be made affordable and she asked the Director-General to use lessons from reducing the costs of antiretroviral medicines to reduce the cost of medicines used to treat viral hepatitis. She welcomed the new HIV treatment guidelines, but said that many low- and middle-income countries would require support to implement them. The number of new infections, especially in girls and women, in southern and eastern Africa was a major cause of concern. It was essential to accelerate socio-behavioural research and the search for a vaccine. With regard to sexually transmitted infections, she was concerned about penicillin shortages and the high cost of human papillomavirus vaccines. She supported all three draft strategies.

The representative of the UNITED REPUBLIC OF TANZANIA, speaking on behalf of the Member States of the African Region, said that early diagnosis was an essential component of sexually transmitted infection control, but few countries had the capability to diagnose asymptomatic infections. Syphilis and HIV were the only infections for which inexpensive, rapid tests were available. The development of antimicrobial-resistant gonococci meant countries had to invest more in laboratory diagnosis and establishing surveillance systems to monitor antimicrobial resistance, an area in which most African countries needed support. Access to effective medicines, including penicillin, remained a challenge. The global strategy should provide a framework for countries to improve and accelerate sexually transmitted infections programmes and ensure that strategies, especially those to improve screening, vaccines and treatment, were operational. Funding for sexually transmitted infections had traditionally been included in HIV/AIDS programmes but, as a result of limited HIV funding and increased demand for antiretrovirals, it had decreased significantly. Sexually transmitted infections affected all segments of the population, including women and adolescents, and therefore

related programmes and their funding must be prioritized. He called for the adoption of the draft strategy on HIV, which would take national contexts and existing national plans into account.

The representative of SAUDI ARABIA said that the elimination of hepatitis C was more feasible than ever as many effective medicines were available, even for advanced stages of the disease, even though they were not available in sufficient quantities or at affordable costs. One solution was to manufacture generics, but measures taken so far in that regard had not satisfied market needs and some such medicines did not meet quality control standards. He therefore called for coordinated international efforts to find innovative funding solutions for the production of the relevant medicines and urged Member States to encourage the production of high quality generics. Partnerships must be forged with the pharmaceutical industry to that end, along the lines of existing partnerships for the production of medicines to treat HIV/AIDS. Urgent action was needed, especially in view of the fact that more than 70% of those carrying the hepatitis C virus were unaware that they were infected.

The representative of FRANCE welcomed the three draft strategies but stressed the need for the international community to speed up efforts to eliminate the epidemics concerned. The relevance of adopting an integrated approach to implementation of the HIV strategy in order to avoid treating pathologies separately was illustrated by the fact that tuberculosis was a leading cause of death among patients with HIV. She welcomed the cross-cutting approach adopted in the draft strategy on sexually transmitted infections and the references to antimicrobial resistance and co-infections. She called upon Member States to adopt the draft strategies.

The representative of MALAYSIA strongly supported the draft global strategy on viral hepatitis and welcomed the service coverage targets to be reached by 2020 and 2030. The treatment targets for hepatitis C might not be reached because life-saving medicines were still too expensive. She urged the Secretariat to negotiate with the pharmaceutical industry to bring prices down to affordable levels.

The representative of MALDIVES said that, despite a low prevalence of HIV, her country prioritized preserving that status through every possible means. With regard to combating viral hepatitis, Maldives had achieved good progress in areas such as childhood hepatitis B vaccine coverage and blood safety, but recognized that elimination would need further efforts. She endorsed the global health sector strategies for HIV and viral hepatitis, agreeing with the representative of Thailand that they should be adapted to country needs.

The representative of the ISLAMIC REPUBLIC OF IRAN welcomed the new strategy on HIV as the current response to the AIDS epidemic was inadequate. The HIV care cascade approach was a valuable prototype and he asked the Secretariat to give it further support. Extensive planning was needed for the prevention and treatment of chronic viral hepatitis, especially to ensure the availability of low-price medicines. The strong association between chronic hepatitis and unsafe injections, high-risk sexual practices and injecting drugs suggested that the viral hepatitis and HIV programmes might usefully be integrated. The Secretariat should promote the approach of identifying and targeting populations and locations, which was a useful tool for tackling sexually transmitted infections, and support the initiative of integrating sexually transmitted infections in the primary health care system. The relationship between drug use, sexually transmitted infections and high-risk sexual practices should be highlighted, and consideration given to sustainable funding for implementation.

The representative of BRAZIL welcomed the three draft strategies and emphasized the importance of caring for the sexual and reproductive health of key populations. The strategies, in particular the viral hepatitis strategy, should target all drug users and not be limited to people who injected drugs. In 2015, in order to overcome the challenge of high-cost medicines, including those for hepatitis C, South American health ministers had agreed to establish a joint purchasing platform in partnership with PAHO and to create a database referencing prices in the region. Brazil was

committed to working nationally and within a PAHO-supported regional initiative to meet the goal of eliminating mother-to-child transmission of HIV and syphilis. The success of public policies hinged on overcoming a global shortage of penicillin, however, which issue needed to be discussed urgently in order to avoid future shortages. He expressed grave concern about recent arbitrary increases in the prices of medicines for opportunistic infections related to HIV/AIDS, which had adversely affected the treatment of those most in need.

The representative of ECUADOR said that she supported the three draft strategies.

The representative of MALI, speaking on behalf of the Member States of the African Region, welcomed the HIV strategy and called for its approval. The provision of services for HIV/AIDS and sexually transmitted infections should focus in particular on the most vulnerable target groups, such as sex workers. The most vulnerable target and high-risk groups should be determined by Member States according to national context, and, as behavioural change was decisive for achieving results, community action should be emphasized. During the transition period before implementation of the new strategy, it was important to maintain progress already made. The suggested means of ensuring the financial viability of implementation needed to be scrutinized according to context to determine the choices to be made and ensure sustainability. Partners' support would have to be redirected to enable measures to be put in place through national funding. The support that had been forthcoming must continue in order to maintain progress and facilitate the gradual establishment of domestic financing mechanisms. He supported the strategy, emphasized the need for concerted action within a strengthened accountability framework and invited all concerned to participate fully in the United Nations General Assembly's High-level Meeting on Ending AIDS, to be held in June 2016.

The representative of PAPUA NEW GUINEA supported all three draft strategies. They were vital for his country, which had one of the highest burdens of the three diseases in the Western Pacific Region, although good data were lacking. Some progress was being made against HIV, including prevention and treatment, but his country would need support to implement the strategies, whose adoption he supported.

The representative of VIET NAM supported the three draft global health sector strategies. With technical assistance from the Secretariat, the draft strategy on HIV would guide her country in its continuing efforts to tackle the epidemic. She requested support for setting up a viral hepatitis surveillance system, and urged the Secretariat to seek a mechanism that offered access to cheaper medicines for hepatitis B and C. Funding of the sexually transmitted infections strategy would be facilitated by showing that programmes were clinically effective and cost-effective in preventing cancer as well as sexually transmitted infections including HIV. She requested the Secretariat's support also in finding cheaper human papillomavirus vaccines, and vaccines for other sexually transmitted infections.

The representative of JAMAICA said that, with significant support from international donor agencies, her country had made considerable progress in its response to HIV. Although investment in the HIV programme was a priority, economic constraints made its expansion impossible without external support. With regard to viral hepatitis, she urged the Secretariat to provide support to enable countries to assess their burden. Priority should be given to action under strategic direction 1: information for focused action. She endorsed the draft global health sector strategies.

The representative of BAHRAIN said that Bahrain had established a national committee to combat HIV/AIDS, which included representatives of both Government and other stakeholders, and had adopted a national programme on HIV/AIDS that was based on the relevant WHO and UNAIDS strategies. It had also taken action to prevent the spread of viral hepatitis and sexually transmitted infections; single use injections were the norm, blood products were screened and all newborn

children were vaccinated against hepatitis B. All pregnant women were screened to prevent transmission to newborn children. Bahrain also screened couples intending to marry and conducted educational campaigns to raise awareness of viral hepatitis and sexually transmitted infections.

The representative of the PHILIPPINES emphasized that a strong combination of health system strengthening, cost-effective public health approaches and a continuum of services was essential in responding effectively to HIV, viral hepatitis and sexually transmitted infections. She expressed support for the three draft global health sector strategies, which would provide Member States with evidence-based interventions and guidance for their respective programmes, as appropriate to their national circumstances.

The representative of RWANDA, welcoming the three draft global health sector strategies, requested the Secretariat to support countries in implementing them as part of comprehensive and integrated patient-centred care. With regard to HIV, his country planned to begin the test-and-treat strategy nationally from July 2016. He drew attention to the reduction in international financial support being given to countries with limited financial and other resources to fight HIV and urged the Secretariat to advocate sustained financial support until sufficient domestic resources became available. He recommended moving from vertical to horizontal support, which had been proven to assist in building resilient and sustainable national health systems.

The representative of the UNITED STATES OF AMERICA said that domestic investment would be critical to the successful implementation of the three draft global health sector strategies, which were well aligned with the goals of the 2030 Agenda for Sustainable Development and to the fast-track approach of the UNAIDS 2016–2021 Strategy. She stressed the need for more efficient and differentiated service delivery models, greater adherence and retention across the treatment cascades, and a focus on reducing the risk of antiviral drug resistance. She also noted that untreated drug use and mental disorders could adversely affect adherence. Member States should clearly articulate how they would reach all key and vulnerable populations. Greater emphasis was needed on cost studies; optimal use of programme and financial data could lead to prioritization, implementation and forecasting. The issues involved were complex, and some of the methods advocated in the three draft strategies could result in unintended consequences. For instance, intellectual property was only one component of access, and it could be important in the development of new medicines; many other factors not addressed in the draft strategies should also be considered. WHO, as a neutral and trusted body, should advocate using the best available evidence and implementing guidelines.

The representative of ESTONIA outlined the steps being taken in his country to tackle the considerable challenge posed by HIV and associated comorbidities. Harm-reduction services were fully funded from the State budget. The European Region was the only WHO region where the number of new HIV infections was still increasing, and injecting drug use accounted for almost half of all new HIV cases in eastern Europe and Central Asia. The epidemic would not be stopped without harm-reduction measures and access to health care and social services. He called on the Secretariat to support Member States in that regard. The unified format of the three draft global health sector strategies was a welcome innovation, which should be mirrored in other WHO policy documents. He expressed specific support for the draft strategy on HIV and urged adoption of the draft resolution.

The representative of SURINAME, expressing support for the draft global health sector strategy on HIV, underlined the importance of monitoring progress. She urged the Secretariat to provide country-specific guidance on adapting monitoring tools to national circumstances. Countries would also look to the Secretariat for guidance on integrating health services related to other diseases such as viral hepatitis, tuberculosis and noncommunicable diseases with HIV services. She further urged the Secretariat to support countries in securing the funding and technical assistance that would enable them to implement the draft strategy.

The representative of SENEGAL said that an integrated global management strategy was needed to tackle co-morbidities associated with HIV infection. Such a strategy should reflect the reality in each country and should serve as an example in dealing with hepatitis B and C co-infections. Additional measures were needed to diagnose viral hepatitis and provide access to treatment. He expressed support for the draft global health sector strategy on viral hepatitis, and suggested that a mechanism be established to monitor its implementation within the various WHO regions.

The representative of SLOVAKIA, expressing support for the comments made by the delegates of Japan, China and Malta, said that it was important to promote a healthy lifestyle, rather than focusing on dealing with the consequences of risky behaviour and promiscuity, which could lead to vulnerability, poverty and poor health. Creating a protective environment and instilling positive values in children and adolescents would help to prevent sexually transmitted infections and mental health issues in future generations. The Secretariat might consider collecting best-practice examples of approaches in that area, as healthy lifestyle and prevention solutions cost a fraction of treatment.

The representative of GREECE, emphasizing the dilemma his country faced in trying to uphold every person's right to proper treatment when resources were limited by external constraints, said that plans to eliminate hepatitis C required a combination of prevention, harm reduction, inclusion criteria for new therapies, and measures to control the spread of the disease. In addition to political commitment, the participation of patients and society was needed in setting priorities. Exchange of expertise and experience among countries could also prove valuable. His country was committed to tackling hepatitis C, through the development of a national action plan and with support from the Secretariat.

The representative of NIGERIA described some of the steps his country had taken to tackle the diseases covered by the three draft strategies and emphasized the need for a comprehensive and integrated approach. Local capacity-building was needed to strengthen health systems, particularly for developing countries that were largely dependent on development partners. Political commitment to the full implementation of the 2001 Abuja Declaration was needed, along with adequate funding. Public-private partnerships should be explored, and social health insurance should be considered as a component of achieving universal health coverage. He expressed support for the draft resolution contained in document A69/59.

The representative of POLAND expressed full support for the three draft global health sector strategies submitted and echoed the comments made by the delegate of Slovakia.

The representative of CHILE expressed support for the draft global health sector strategy on viral hepatitis, noting that the epidemiological characteristics of viral hepatitis and its main causes of transmission varied from country to country. She outlined progress made in her country in tackling the disease and expressed appreciation to Brazil for its assistance in providing access to medicines.

The representative of INDIA noted with satisfaction that the draft global health sector strategy on HIV emphasized linkages with co-infections, such as tuberculosis and hepatitis. He called for the development of linkages with noncommunicable diseases, such as mental health. Noting that emphasis should be placed on ensuring access to affordable medicines, he highlighted India's contribution to ensuring access to high-quality generic HIV medicines. The draft global health sector strategy on viral hepatitis should place greater emphasis on prevention, with the development of a hepatitis C vaccine a priority. Regarding the draft global health sector strategy on sexually transmitted infections, he asked WHO to provide more scientific evidence on the effectiveness of human papillomavirus vaccination. In view of competing demands for funding for the health-related Sustainable Development Goals, ensuring the availability of the resources required to achieve the ambitious milestones for 2020 would be challenging.

The observer of CHINESE TAIPEI outlined some of the steps being taken, progress made and challenges faced in dealing with viral hepatitis in Chinese Taipei, where treatment was still limited by high costs. With the aim of reducing discrimination, entry and residence restrictions on people living with HIV had been removed. Congenital syphilis was now a notifiable disease.

The representative of UNAIDS said that the core of the UNAIDS 2016–2021 Strategy, which was fully aligned with the Sustainable Development Goals, was to lay the foundations for an evidence- and rights-based approach to ending the AIDS epidemic. WHO's draft global health sector strategy on HIV was a key component of the multisectoral AIDS response set out in the UNAIDS Strategy, with which it was fully aligned. Adoption of the draft strategy would send a strong signal of commitment to ending AIDS as a public health threat by 2030 and to addressing HIV-related discrimination in all societies. UNAIDS would continue to work closely with WHO as the draft strategy was implemented.

The observer of the INTERNATIONAL FEDERATION OF RED CROSS AND RED CRESCENT SOCIETIES welcomed the draft global health sector strategy on HIV. The final version should include clear targets and commitments on the needs and rights of each key population group; reducing HIV transmission among people who injected drugs; specific ways to involve people living with HIV, communities and affected groups in future action and to remove barriers; the need for affordable HIV treatment; and the need for commitment from Member States and donors to fund the global AIDS response fully.

The representative of GLOBAL HEALTH COUNCIL, INC., speaking at the invitation of the CHAIRMAN, welcomed the draft global health sector strategy on HIV, noting with satisfaction the priority attached to eliminating vertical transmission. She strongly encouraged countries to increase their efforts in that regard and to obtain certification of elimination. She welcomed the focus on paediatric treatment and would support differentiated care and service delivery models, but added that such models should be differentiated by age group, in view of the specific risks associated with infants, children and adolescents.

The representative of the INTERNATIONAL AIDS SOCIETY, speaking at the invitation of the CHAIRMAN, welcomed all three draft global health sector strategies but emphasized that their successful implementation would depend, in part, on a motivated and trained health workforce. With regard to the draft strategy on HIV, he called for a continued focus on key populations and on ensuring access to scientific advancements in the area of protection. Advances could be achieved with respect to the ambitious draft strategy on viral hepatitis through linkages with other programmes. For the draft strategy on sexually transmitted infections, it was important to ensure that men and boys had access to sexual and reproductive health and HIV-related services. WHO should focus on the linkages between the three draft global health sector strategies and supported their implementation.

The representative of the INTERNATIONAL FEDERATION OF MEDICAL STUDENTS' ASSOCIATIONS, speaking at the invitation of the CHAIRMAN, welcomed the three draft global health sector strategies, which offered a framework for a people-centred and human-rights based approach to health care for those with, or at risk of contracting, HIV and other sexually transmitted infections. She opposed any action by Member States to restrict young people's access to education and information on sexual and reproductive health, and noted the importance of broad intersectoral partnerships and civil society involvement in achieving the target of ending the AIDS epidemic by 2030.

The representative of the INTERNATIONAL PLANNED PARENTHOOD FEDERATION, speaking at the invitation of the CHAIRMAN, welcomed the three draft global health sector strategies, in particular the draft global health sector strategy on sexually transmitted infections. He praised the emphasis given to such aspects as equity, financing, innovation, gender equality and human rights.

The linkage to sexual and reproductive health was encouraging; greater integration of related services and programmes had the potential to reduce costs and lead to better outcomes. Implementation of the draft strategies would require political support, financial investment and integration in existing health systems. He called on Member States to show the leadership required in all forums, particularly at the United Nations General Assembly's High-level Meeting on Ending AIDS in June 2016 and the Fifth Replenishment Conference of the Global Fund to Fight AIDS, Tuberculosis and Malaria in September 2106. He supported the draft resolution.

The representative of MÉDECINS SANS FRONTIÈRES INTERNATIONAL, speaking at the invitation of the CHAIRMAN, welcomed the draft global health sector strategy on HIV. She would welcome provision of antiretroviral therapy to all people with HIV on diagnosis, emphasizing that test-and-treat programmes should be provided to all, not just specific populations or hardest hit regions. She also welcomed the draft global health sector strategy on viral hepatitis, but its goals could be achieved only if governments implemented ambitious immunization programmes, took action against overpriced medicines, reduced the regulatory lag time for registration of new medicines, refused pharmaceutical companies' unethical anti-diversion policies, and guaranteed universal access to high-quality diagnostic tools and generic medicines. She urged Member States to endorse the draft strategies and provide the resources necessary for their timely and large-scale implementation.

The representative of the MEDICINES PATENT POOL, speaking at the invitation of the CHAIRMAN, welcomed the draft global health sector strategies on HIV and viral hepatitis, which highlighted the need to ensure quality and affordable medicines, for instance through voluntary licences. His organization's work with originator and generic companies had enabled more affordable access to WHO-recommended treatments for HIV in more than 100 countries, and its recent action on hepatitis C would permit manufacture of a generic version of a WHO-recommended treatment for supply to more than 112 countries. His organization was willing to continue to collaborate with the Secretariat and Member States to increase access to affordable treatments for HIV and viral hepatitis in developing countries.

The representative of MEDICUS MUNDI INTERNATIONAL – INTERNATIONAL ORGANISATION FOR COOPERATION IN HEALTH CARE, speaking at the invitation of the CHAIRMAN, said that the three draft global health sector strategies failed to explain how key barriers would be overcome, notably: how low- and middle-income countries would raise the domestic resources necessary to expand their response to HIV; the high costs of trademarked diagnostic tools and medicines for hepatitis B and C; and inadequate provision of clean drinking water and sanitation. She urged the Secretariat to provide technical support to Member States on using the flexibilities in the Agreement on Trade-Related Aspects of Intellectual Property Rights to introduce generic versions of new treatments for hepatitis C. The opportunity cost of adding the human papillomavirus vaccine to the routine immunization schedule must be carefully considered, given that low-income countries were already struggling to maintain current immunization schedules.

The representative of the WORLD HEPATITIS ALLIANCE, speaking at the invitation of the CHAIRMAN, said that the draft global health sector strategy on viral hepatitis was the single most important document ever on viral hepatitis. It went further than Sustainable Development Goal 3 by moving to eliminate, rather than merely combat, hepatitis B and C as a public health threat by 2030, and included clear targets to drive action that would also strengthen health systems. Its ambitious objective could be achieved with clear political will from Member States, and he called for adoption of the draft strategy.

The ASSISTANT DIRECTOR-GENERAL (HIV/AIDS, Tuberculosis, Malaria and Neglected Tropical Diseases) thanked the speakers for their positive comments. HIV and viral hepatitis continued to present a major threat to public health, and the draft global health sector strategies maintained a

clear focus on disease while providing a road map for the greater integration of high-impact, disease-specific interventions and services into national health programmes and systems. With regard to cost, he recalled that the draft resolution urged Member States to implement the proposed actions “adapted to national priorities, legislation and specific contexts”. Although the strategies introduced ambitious targets and called for increase overall investment in health, major opportunities existed to reduce the cost of diagnosis, medicines and services, by means of, for instance, comprehensive price-reduction strategies and decentralized services. The high cost of hepatitis C treatment was challenging, particularly in resource-limited contexts, but was being significantly reduced in a number of low- and middle-income countries as a result of the introduction of generic medicines. Resolutions adopted by the Health Assembly would also help to increase access to and affordability of medicines and provide new platforms to address the high prices of such treatment. Prevention of antimicrobial resistance was critical to the draft global health sector strategies on HIV and viral hepatitis. There was a need to ensure that issues relevant to HIV and viral hepatitis were adequately reflected in work on antimicrobial resistance, and an action plan on addressing HIV drug resistance, which was closely linked to the global action plan on antimicrobial resistance, was under development. The Secretariat would continue to work closely with the Global Fund to Fight AIDS, Tuberculosis and Malaria and other partners to ensure that the three global health sector strategies were widely promoted and implemented.

The ASSISTANT DIRECTOR-GENERAL (Family, Women’s and Children’s Health) said that the three draft global health sector strategies were based on the concept of universal health coverage. Some success had already been achieved from the integration of activities addressing sexually transmitted infections, such as the elimination of mother-to-child transmission of HIV and syphilis in Brazil and Cuba. Integration of the draft strategies with the adolescent health programme was also important, particularly with respect to prevention activities and human papillomavirus vaccination. The Secretariat would be pleased to provide the evidence that Member States required to make policy decisions; more than 30 countries had already introduced human papillomavirus vaccination for adolescent girls, and much had been learned about the best service delivery model. The cost of the vaccine – a critical limitation – was continuing to decrease. Regarding the important link to antimicrobial resistance, she reported that the results of WHO’s work on additional diagnostic tools and recommendations for surveillance, including with respect to gonorrhoea, were due to be published in July 2016. The draft strategies should, first and foremost, be financed by Member States, but funding could and should be supplemented by the Global Fund to Fight AIDS, Tuberculosis and Malaria, UNITAID, the GAVI Alliance and others. The Secretariat was actively exploring ways of working more effectively with such funding instruments to provide the resources required.

The draft resolution was approved.¹

2. THIRD REPORT OF COMMITTEE B (document A69/74)

The RAPPORTEUR read out the draft third report of Committee B.

The report was adopted.²

The meeting rose at 12:40.

¹ Transmitted to the Health Assembly in the Committee’s fourth report and adopted as resolution WHA69.22.

² See page 384.

SEVENTH MEETING

Saturday, 28 May 2016, at 14:10

Chairman: Dr PHUSIT PRAKONGSAI (Thailand)

later: Dr M. ASADI-LARI (Islamic Republic of Iran)

later: Dr PHUSIT PRAKONGSAI (Thailand)

1. COMMUNICABLE DISEASES: Item 15 of the agenda (continued) [transferred from Committee A]

Global vaccine action plan: Item 15.2 of the agenda (document A69/34)

The representative of BURKINA FASO, speaking on behalf of the Member States of the African Region, recalled that the objective of the global vaccine action plan was to expand vaccination coverage in the period 2011–2020 to all people, irrespective of their location; its targets were ambitious, but remained achievable. Several challenges hindered implementation of the Expanded Programme on Immunization in the Region, including the accessibility, cost and availability of vaccines, especially during emergency situations such as the current yellow fever epidemic in Angola. To ensure the successful implementation of the global vaccine action plan, further efforts were required, including: a review of the criteria of the International Coordinating Group on Vaccine Provision for Epidemic Meningitis Control for releasing vaccine supplies; the establishment of regional stockpiles of vaccines; the facilitation of access to vaccination services by allocating sufficient funding; and the improvement of the accessibility and availability of vaccines – in keeping with the targets identified in the 2030 Agenda on Sustainable Development. The Member States of the Region were committed to implementing the recommendations of the WHO Strategic Advisory Group of Experts on immunization¹ and requested support from the Secretariat to that end; he urged the Health Assembly to endorse those recommendations.

The representative of the REPUBLIC OF KOREA acknowledged the efforts of the international community to achieve the goals of the global vaccine action plan. The issue of vaccination merited increased attention on the global health agenda in view of its pivotal role in ensuring global health security, including further investment in research and development for the production of safe and efficacious vaccines at the national, regional and international levels and the importance of strengthening surveillance systems. To support international efforts, her Government had decided to increase its contributions to the GAVI Alliance from US\$ 1 million to US\$ 4 million annually for the next three years. The Republic of Korea would continue its efforts to achieve the goals of the 2011–2020 Decade of Vaccines and the global vaccine action plan.

The representative of SAUDI ARABIA drew attention to the significant challenge currently faced by his country in relation to the elimination of measles, which posed a serious threat to global health security. Measles had not been accorded sufficient attention at the international level, and the conditions in the Eastern Mediterranean Region were conducive to its spread; for example, the increase of conflict and crisis hindered efforts to reach all those in need of vaccines. The lessons learned from efforts to eliminate poliomyelitis could be usefully applied to efforts invested in

¹ See document A69/34, Annex 1.

eliminating measles, and he urged the Secretariat, Member States, regional offices and the industry to accord maximum attention to the issue.

The representative of SRI LANKA said that the national immunization programme continued to attain high coverage rates, resulting in the prevention and control of most vaccine-preventable diseases; for instance, no case of poliomyelitis, diphtheria or neonatal tetanus had been recorded. In 2015 Sri Lanka had introduced the inactivated poliovirus vaccine, and in the current year had made the switch from trivalent to bivalent oral poliovirus vaccine and introduced the human papillomavirus vaccine. Sri Lanka had prioritized strengthening vaccine-preventable disease surveillance and assessing the performance of the Expanded Programme on Immunization in reducing childhood morbidity and mortality. Innovative options for the financing of routine immunization services at the subnational level were required in order to ensure their sustainability. He endorsed the recommendations of the Strategic Advisory Group of Experts on immunization.

The representative of the RUSSIAN FEDERATION said that her Government welcomed the progress achieved thus far, including the introduction of new vaccines and progress towards the elimination of poliomyelitis. She expressed appreciation of the efforts to review the situation in developing countries, WHO's prequalification process and the technical support required to ensure vaccine availability and accessibility, and broadly supported the recommendations of the Strategic Advisory Group of Experts on immunization, including the proposal to strengthen partnerships at all levels in the work against vaccine-preventable disease including measles and rubella and health systems. Special attention should be paid to populations living in post-conflict situations, where there was a higher risk of the spread of disease.

The representative of the UNITED REPUBLIC OF TANZANIA described the range of measures taken by his country to implement the global vaccine action plan, which included introducing new and under-utilized vaccines, increasing access to vaccines for marginalized populations through the "reach every child" strategy, and developing a comprehensive immunization plan for the period 2016–2020. His country had been certified as having eliminated maternal and neonatal tetanus in 2012 and, as a result of the high national oral poliovirus vaccination coverage, had also achieved "polio-free" certification in November 2015. WHO should continue to strengthen the capacity of developing countries to facilitate their participation in vaccine research and development. He welcomed the collaboration of WHO and UNIDO in the establishment of the African vaccine manufacturing initiative, and WHO's work on the prequalification process. His Government was committed to implementing the recommendations of the Strategic Advisory Group of Experts on immunization.

The representative of THAILAND said that the Secretariat and other development partners should continue to support Member States in strengthening national immunization programmes, as part of efforts towards ensuring universal health coverage. The Expanded Programme on Immunization should develop a list of critical priority actions to be taken at the country level. The success of immunization programmes must not lead to complacency. The potential financial impact and sustainability of new vaccines should be taken into serious consideration by WHO and the WHO Strategic Advisory Group of Experts on immunization before their introduction was recommended. Achievement of the goals of the global vaccine action plan depended to a large extent on the capacity of developing countries to develop and produce vaccines at a low cost; consideration should therefore be given to delinking the cost of research and development from the price of vaccines. Her Government was fully committed to implementing the global vaccine action plan and looked forward to the achievement of the targets related to the Decade of Vaccines.

The representative of the UNITED KINGDOM OF GREAT BRITAIN AND NORTHERN IRELAND said that his Government fully supported the accelerated implementation of the global vaccine action plan and the recommendations of the Strategic Advisory Group of Experts on immunization. His Government was proud to be the largest donor to the GAVI Alliance, having committed to provide £1440 million in funding from 2016 to 2020. WHO should improve the management of the global vaccine stockpile, increase transparency in decision-making, and communicate decisions and actions more clearly. In spite of the continued high national vaccination coverage rates and its success in meeting WHO targets, his Government had not become complacent: the recent introduction of the meningococcal ACWY and B vaccines served as an example. All countries and partners were called on to ensure that progress in achieving the targets related to the Decade of Vaccines remained on track. Member States were urged to increase domestic financing for, and support to, immunization.

The representative of DENMARK, speaking on behalf of the Nordic and Baltic countries, Denmark, Finland, Iceland, Norway, Sweden, Estonia, Latvia and Lithuania, thanked the GAVI Alliance and the Global Polio Eradication Initiative for their coordinated efforts to eradicate poliomyelitis. Although progress had been made in some countries and regions, the elimination strategies for maternal and neonatal tetanus urgently needed revision and additional funding. He welcomed the recommendations of the Strategic Advisory Group of Experts on immunization regarding accountability. Immunization plans that were consistent with the global vaccine action plan should be put in place at the country level and shared with the regional offices. The countries that were no longer qualifying for support from the GAVI Alliance must ensure the availability of sufficient domestic funding for immunization. In order to improve equitable health coverage, immunization programmes should form an integral part of strengthened health systems. He expressed concern at the challenges related to vaccine production and delivery and their concomitant effect on the successful implementation of national vaccination programmes. The recent Ebola and Zika virus outbreaks had highlighted the urgent need for increased efforts to develop new vaccines to prevent and respond to epidemics and pandemics. A coordinated approach was required to counter the dissemination of non-evidence-based information on the possible side effects of vaccines.

The representative of VIET NAM said that her Government strongly supported the recommendations of the Strategic Advisory Group of Experts on immunization. Her Government had successfully implemented the Expanded Programme on Immunization; the national regulatory authority had been accredited by WHO, and Viet Nam was producing vaccines and satisfying national demand. Her Government was committed to implementing the global vaccine action plan, but she highlighted the need for additional support from the Secretariat in order to maintain the operation of the national regulatory authority, enhance national capacity to manufacture vaccines, and maintain high immunization coverage rates.

The representative of CHILE said that concerted and effective action was needed to advance the progress made towards the targets of the global vaccine action plan. Greater priority should be accorded to immunization programmes at the national level, with an emphasis on ensuring free universal access to vaccines. In the light of the increasing dissemination of incorrect information on the effects of vaccines, efforts must be made to promote their efficacy and safety. Noting the importance of communicating the fact that efforts to enforce immunization were based on technical, ethical and legal considerations, she called for support to tackle vaccine refusal. To address the availability and accessibility of vaccines, WHO should promote collective vaccine purchasing, and emphasize the importance of public-private partnerships in developing and producing vaccines in low- and middle-income countries, as well as the need for flexibility in relation to intellectual property protection.

The representative of LIBYA said that, in the light of the current emergency situation, his country was facing significant difficulties in achieving the targets of the global vaccine action plan. Noting that many other countries in the Eastern Mediterranean Region affected by crisis were facing similar challenges, he underscored the urgent need for support for such countries, including solutions to meet the vaccination needs of both the domestic and refugee populations. Given the increasing price of vaccines and the resultant unaffordability for many countries, he called on WHO and other partners to facilitate access to the lowest global price of vaccines for countries facing humanitarian crises. He requested information on how the Secretariat would take action to implement the provisions of resolution WHA68.6 (2015), including those relating to the reduction of vaccine prices. The right of every child and indeed every person, including those living in crisis situations, to be vaccinated with affordable vaccines must be upheld. He looked forward to further progress on the implementation of resolution WHA68.6 in the coming year.

The representative of the UNITED STATES OF AMERICA, noting that the global vaccine action plan was not on track, urged all countries to renew their commitment to achieving its targets. Urgent action was needed to ensure that global vaccine stockpiles were effectively managed by WHO; the current limited supply of yellow fever vaccine was of particular concern. The Secretariat should work with Member States to develop strategies for the vaccination of those living in areas affected by conflict and insecurity. She commended the efforts of Member States of the African Region, which had led to the Declaration on Universal Access as a Cornerstone for Health and Development in Africa at the Ministerial Conference on Immunization in Africa earlier in the year. She expressed support for the recommendations of the Strategic Advisory Group on immunization, in particular the need for global, regional and national partners to align their efforts to support countries in strengthening their leadership and accountability frameworks. She regretted that the monitoring framework for the sustainable development goals did not include an indicator that was aligned with the objectives of the global vaccine action plan. She urged the Secretariat, UNICEF and Member States to: provide guidance on reaching every child, building upon the successful results achieved in relation to poliomyelitis vaccination; conduct robust disease surveillance; provide effective outbreak response; devise culturally appropriate communication strategies; and implement accountability frameworks. The ability of Nigeria to harness the polio infrastructure and model to successfully control the recent Ebola outbreak affirmed the strong case for using polio assets more extensively to contribute to global health security.

The representative of CHINA said that his Government attached great importance to the global vaccine action plan, and welcomed the progress so far. Given the lengthy implementation period for the global vaccine action plan, WHO should regularly review the progress made and challenges remaining. In order to achieve the targeted results, international cooperation should be increased. Support should be provided to facilitate the introduction of new vaccines and technology transfer, and vaccinations should be provided free of charge to school-aged children. China stood ready to cooperate with other Member States in order to achieve the targets of the global vaccine action plan.

The representative of the PHILIPPINES expressed concern that, despite the progress made, challenges remained in attaining the goals of the global vaccine action plan. She highlighted the need to ensure equity and the importance of WHO's leadership role in ensuring that populations in areas affected by crisis and countries with a high burden of disease had access to affordable, life-saving vaccines. Her Government supported the recommendations of the Strategic Advisory Group of Experts on immunization.

The representative of SOUTH AFRICA said that the lack of availability, shortages and stock-outs of vaccines had wide public health implications and hindered progress towards the objectives related to antimicrobial resistance. In response to the need for urgent action to ensure that suppliers had sufficient capacity to respond to the global demand, the Secretariat should convene a team on

vaccine market dynamics to develop strategies for securing vaccine supply. In view of the prohibitive cost of vaccines, especially for developing countries, the Secretariat should accelerate the work on vaccine pricing, including the establishment of a database of global vaccine prices. It should prepare guidelines on accessibility to affordable vaccines for populations in crisis situations. In addition, it should fast-track the objectives of the global vaccine action plan, particularly in relation to availability and affordability.

The representative of IRAQ, speaking on behalf of the Member States of the Eastern Mediterranean Region, said that the Region was on track for the achievement of the regional hepatitis B control target and the introduction of new and under-utilized vaccines. Several countries in the Region continued to face great challenges because of their security situation; more than 95% of the unvaccinated children in the Region were in those countries. As part of their commitments to implement the global vaccine action plan, countries and partners should allocate and mobilize more financial resources and establish a process for monitoring and accountability at national and subnational levels, through the National Immunization Technical Advisory Group. Significant support from partners, in terms of funding and technological transfer, would be needed to ensure access to immunization in countries in crisis and overcome the global shortage of some vaccines. Greater effort should be made to reduce the cost of new life-saving vaccines. Resources were also required to overcome the bottlenecks in maternal and neonatal tetanus elimination. Member States of the Region supported the recommendations of the Strategic Advisory Group of Experts and the proposal to present the assessment report to the World Economic Forum in Davos in order to mobilize necessary resources.

The representative of MALAYSIA said that the affordability of new vaccines and the rising numbers of vaccine refusals continued to hinder attainment of the targets in the global vaccine action plan. Malaysia had experienced a stock-out of a combination inactivated poliovirus and acellular pertussis vaccine, which had disrupted the vaccination schedule, and she urged the Secretariat to ensure that supply-side interventions were matched with demand-consolidation activities relating in particular to strengthening national decision-making and the national financing of immunization programmes.

The representative of INDONESIA said that it was important for WHO to put in place a proper mechanism for vaccine procurement in order to make vaccines available and affordable. Maternal and neonatal tetanus had been eliminated in Indonesia. Her Government encouraged WHO and its partners to facilitate technology transfer and capacity-building for vaccine manufacturing. All child health stakeholders were called on to support and mobilize resources in order to enable all children to have access to quality immunization services.

The representative of NIGER said that, despite the efforts of her Government since 2010 to put in place an action plan for vaccines, including the highly effective campaign to introduce meningococcal A vaccine as part of its routine vaccination programme, there had been an outbreak of more than 7000 cases of meningitis in 2015. The causative agent in more than 75% of the more than 470 deaths had been group C meningococci and group W meningococci in about 15%. The global shortage of vaccines against those strains and their exorbitant cost had posed serious difficulties for the authorities at that time. WHO's contribution was recognized but more was needed. The Organization should advocate wider availability of the tetravalent vaccine and a reduction in its cost.

The representative of the GAVI ALLIANCE, speaking at the invitation of the CHAIRMAN, concurred that the Decade of Vaccines was not on course to achieve its objectives. Reaching underserved populations with life-saving vaccines was challenging, particularly in the context of humanitarian crises. In the second half of the Decade of Vaccines, emphasis on coverage and equity

was needed to ensure that the key targets of the global vaccine action plan were met. Her organization planned to increase its efforts to help countries to plan for the transition away from eligibility for its support so as to ensure the sustainability of immunization systems. It was also important to build sustainable health systems in countries and to pursue an international approach to ensuring vaccine access in the event of disease outbreaks. The monitoring framework for the 2030 Agenda for Sustainable Development would provide an excellent platform to reinvigorate global commitment to the Action Plan. The GAVI Alliance advocated the inclusion of a specific immunization indicator in the monitoring framework and called for the support of Member States and others in that regard.

The observer of CHINESE TAIPEI welcomed the recommendations of the Strategic Advisory Group of Experts on immunization in connection with strengthening accountability in implementing plans and improving immunization coverage rates among unvaccinated children in marginalized regions. The Secretariat was encouraged to promote collaboration in immunization programmes, to support the international community in meeting vaccination coverage targets, and to coordinate efforts in increasing regional vaccine production capacity. Chinese Taipei stood willing to share its expertise regarding its immunization information system on vaccination coverage among children and its experiences in successfully implementing immunization programmes with its partners.

The observer of the INTERNATIONAL FEDERATION OF RED CROSS AND RED CRESCENT SOCIETIES called on Member States to take action by: sharing information on vaccine prices with WHO; engaging in shared leadership with civil society; and matching supply-side interventions with demand-side activities, including through dialogues with communities. He called on the Secretariat to: provide guidance to Member States and partners on the vital role that civil society organizations can play in the implementation of a critical package of health services, including immunizations, to populations living in areas of conflict; support better coordination between governments and civil society organizations with regard to the global vaccine action plan accountability framework; and provide more online course offerings related to immunization.

The representative of MÉDECINS SANS FRONTIÈRES INTERNATIONAL, speaking at the invitation of the CHAIRMAN, encouraged Member States to continue to share their price data with WHO. High prices were preventing her organization from being able to scale-up vaccinations for children in crisis-affected areas; pharmaceutical companies were offering no sustainable solution. In addition to accelerating competition among vaccine companies, WHO should use its expertise to facilitate a review of the pneumococcal conjugate vaccine candidates from emerging economy manufacturers in order to cut waiting times for the next product.

The representative of the INTERNATIONAL PHARMACEUTICAL STUDENTS' FEDERATION, speaking at the invitation of the CHAIRMAN, endorsed positive collaboration between national regulatory bodies, the pharmaceutical companies, health practitioners and medicine retailers. Member States should incorporate immunization training within all pharmacy curricula and provide research internships to pharmacy students. As pharmacists reached community members on a daily basis, Member States should include pharmacy students and professionals in public health campaigns to tackle vaccine hesitancy and educate the public on the rarity of adverse effects.

The ASSISTANT DIRECTOR-GENERAL (Family, Women's and Children's Health) said that tremendous progress had been made in four main areas of the global vaccine action plan, namely: the introduction of new vaccines, including the development of the new Ebola vaccine; polio eradication; the eradication of maternal and neonatal tetanus, particularly in India and the South-East Asia Region in general; and vaccine price sharing. Already 40 Member States had shared information on vaccine pricing with WHO, but much more needed to be done; the Secretariat would work on continuing to shape the market in order to drive down vaccine prices. Turning to the concerns expressed by Member States, she said that a global mid-term review on measles was under way to provide recommendations

on how to strengthen control and elimination of measles, mumps and rubella. The Director-General had recently commissioned an evaluation on how to improve the management of vaccine stockpiling. The GAVI Alliance would focus on reducing inequity in vaccination coverage. A discussion had been initiated on how best to use the assets of the polio eradication programme to advance the other goals of the global vaccine action plan. The positive, high-level political commitment to vaccinations and immunization in Africa was encouraging. Plans were in place to develop the WHO workforce, particularly in countries experiencing emergencies and crises, and to devote more resources to promoting the health of women and children in displaced settings.

The Committee noted the report.

2. HEALTH SYSTEMS: Item 16 of the agenda (continued) [transferred from Committee A]¹

Follow-up to the report of the Consultative Expert Working Group on Research and Development: Financing and Coordination – Report of the open-ended meeting of Member States: Item 16.2 of the agenda (document A69/40) (continued from the fourth meeting, section 2)

The CHAIRMAN invited the Committee to consider the following revised version of the draft resolution:

The Sixty-ninth World Health Assembly,

PP1 Recalling WHA66.22 and subsequent WHA decisions on the Follow-up of the Report of the Consultative Expert Working Group on Research and Development: Financing and Coordination and noting progress made in the implementation of the Strategic Workplan agreed in WHA66.22;

PP2 Acknowledging that the 2030 Agenda for Sustainable Development includes the commitment to support the research and development of vaccines and medicines for the communicable and noncommunicable diseases that primarily affect developing countries, provide access to affordable medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use to the full the provisions in the Agreement on Trade-Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health, and, in particular, provide access to medicines for all;

PP3 Recalling the Global strategy and plan of action on public health, innovation and intellectual property and its aims to promote innovation, build capacity, improve access and mobilize resources to address diseases that disproportionately affect developing countries;

PP4 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;

PP5 Noting the establishment of the High-Level Panel on Access to Medicines convened by the UN Secretary-General;

PP6 Underscoring that health research and development should be needs-driven and evidence-based and be guided by the following core principles: affordability, effectiveness, efficiency, and equity; and it should be considered as a shared responsibility;

¹ See the summary record of the General Committee, first meeting, section 2.

PP7 Acknowledging the central role of the Global Observatory on Health Research and Development to consolidate, monitor and analyze relevant information on health research and development activities related to type II and III diseases and the specific research and development needs of developing countries in relation to type I diseases, as well as for potential areas where market failures exist, and also antimicrobial resistance and emerging infectious diseases likely to cause major epidemics, building on national and regional observatories (or equivalent functions) and existing data collection mechanisms, with a view to contributing to the identification and the definition of gaps and opportunities for health research and development priorities and supporting coordinated actions on health research and development;

PP8 Expressing concern at the significant gap in funding the Strategic Workplan agreed in WHA66.22, including the six selected demonstration projects,

(OP1) URGES Member States:¹

- (1) to make concerted efforts including through adequate and sustainable funding to fully implement the Strategic Workplan agreed in WHA66.22;
- (2) to create, operationalize and strengthen, as appropriate, national health research and development observatories or equivalent functions for tracking and monitoring of relevant information on health research and development and to provide regular information on relevant health research and development activities to the Global Observatory on Health Research and Development or to other existing data collection mechanisms which provide regular reports to the Global Observatory on Health Research and Development;
- (3) to provide support to the Director-General for the development of sustainable financing mechanisms for the full implementation of the Strategic Workplan agreed in WHA66.22;

(OP2) REQUESTS the Director-General:

- (1) to expedite the full implementation of the Strategic Workplan agreed in WHA66.22;
- (2) to expedite the further development of a fully functional Global Observatory on Health Research and Development;
- (3) to submit terms of reference and a costed workplan of the Global Observatory on Health Research and Development to the Seventieth World Health Assembly through the 140th session of the Executive Board under the CEWG related agenda item;
- (4) to expedite, as part of the development of the Global Observatory on Health research and development, the development of norms and standards for classification of health research and development, including common reporting formats, building on existing sources, in consultation with Member State experts and relevant stakeholders in order to collect and collate information systematically;
- (5) to promote the Global Observatory on Health Research and Development among all stakeholders, including through regular open-access publications and outreach activities and encourage all stakeholders to regularly share relevant information on health research and development with the Global Observatory on Health Research and Development;
- (6) to support Member States in their endeavours to establish or strengthen health research and development capacities including the monitoring of relevant information on health research and development;
- (7) to establish a WHO Expert Committee on Health R&D to provide technical advice on prioritization of health research and development for Type II and III diseases and

¹ And, where applicable, regional economic integration organizations.

specific research and development needs of developing countries in relation to Type I diseases as well as for potential areas where market failure exists based, inter alia, on the analyses provided by the Global Observatory on Health Research and Development. The Expert Committee will, as needed, consult with all relevant stakeholders in carrying out its work as specified in its terms of reference, which will be formulated and submitted to the 140th session of the Executive Board for its consideration;

(8) to take into account the study conducted by the UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases, and on the basis of the report of the CEWG, present a proposal with goals and an operational plan for a voluntary pooled fund to support research and development for Type III and Type II diseases and specific research and development needs of developing countries in relation to Type I diseases, to be submitted to the Seventieth World Health Assembly through the 140th session of the Executive Board;

The plan shall describe how the WHO Global Observatory on Health Research and Development, the WHO Expert Committee on Health Research and Development and the Scientific Working Group of a pooled fund will work together, with specific disease examples, and in line with the core principles of affordability, effectiveness, efficiency, equity and the principle of delinkage. The plan shall also provide options for sustainable funding;

(9) to promote and advocate for sustainable and innovative financing for all aspects of the Strategic Workplan agreed in WHA66.22 and to include, as appropriate, the Strategic Workplan in WHO financing dialogues for mobilizing sufficient resources to meet the objectives of WHA66.22;

(10) to promote policy coherence within WHO on its research and development related activities such as those in relation to the Research and Development Blueprint for Emerging Pathogens and the Global Action Plan on Antimicrobial Resistance in terms of application of the core principles of affordability, effectiveness, efficiency and equity and the objective of de-linkage identified in WHA66.22;

(11) to report to the Seventieth World Health Assembly, through the 140th session of the Executive Board, on the implementation of this resolution, and request the Seventieth World Health Assembly to consider convening another open-ended meeting of Member States in order to assess progress and continue discussions on the remaining issues in relation to monitoring, coordination and financing for health research and development, taking into account relevant analyses and reports.

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

Resolution: Follow-up of the report of the Consultative Expert Working Group on Research and Development: Financing and Coordination	
A. Link to the general programme of work and the programme budget	
1.	Please indicate to which impact and outcome in the Twelfth General Programme of Work, 2014–2019 and which output in the Programme budget 2016–2017 this draft resolution will contribute if adopted.
	Improved access to and rational use of safe, efficacious and quality medicines and health technologies.
	Outcome: 4:3
	Output: 4.3.2

<p>2. If there is no link to the results as indicated in the Twelfth General Programme of Work, 2014–2019 and the Programme budget 2016–2017, please provide a justification for giving consideration to the draft resolution.</p> <p>Not applicable.</p>			
<p>3. What is the proposed timeline for implementation of this resolution?</p> <p>2016–2017 and 2018–2019.</p> <p><i>If the timeline stretches to future programme budgets, please ensure that further information is provided in the costing section.</i></p>			
B. Budgetary implications of implementation of the resolution			
1. Current biennium: estimated budgetary requirements: US\$ 9.5 million			
Level	Staff	Activities	Total
Country offices	–	–	–
Regional offices	–	–	–
Headquarters	5	4.5	9.5
Total	5	4.5	9.5
<p>1(a) Is the estimated budget requirement in respect of implementation of the resolution fully included within the current programme budget? (Yes/No)</p> <p>YES – for the Global Observatory on Health Research and Development and the coordination mechanism. NO – under the programme budget for the health research and development demonstration projects (US\$ 30 million).</p>			
<p>1(b) Financing implications for the budget in the current biennium:</p> <p>– How much is financed in the current biennium? US\$ 1.7 million</p> <p>– What are the gaps? US\$ 7.8 million for the work under the programme budget; US\$ 30 million for the demonstration projects (outside the programme budget).</p> <p>– What action is proposed to close these gaps? The gap will be addressed through the coordinated resource mobilization efforts including the financing dialogue for possible financing by voluntary contribution.</p>			
2. Next biennium: estimated budgetary requirements, in US\$ millions			
Level	Staff	Activities	Total
Country offices	–	–	–
Regional offices	–	–	–
Headquarters	7	6	13
Total	7	6	13

2(a) Financing implications for the budget in the next biennium:**– How much is currently financed in the next biennium?**

US\$ 1 million

– What are the financing gaps?

US\$ 12 million for activities under the programme budget and US\$ 50 million for the demonstration projects, outside the programme budget.

– What action is proposed to close these gaps?

The gap will be addressed through the coordinated resource mobilization efforts as mandated in operative paragraph 2(9) of the resolution.

The draft resolution, as amended, was approved.¹

The representative of INDIA, speaking as chairman of the drafting group that had successfully negotiated and finalized the draft resolution the previous day, expressed the hope that the adoption of the resolution would pave the way for the accelerated development of the Global Health Observatory on Health Research and Development, the implementation of the demonstration projects and the coordination mechanism, and the rapid overcoming of the funding difficulties that hindered the work of the Consultative Expert Working Group on Research and Development.

The representative of GERMANY, welcoming the approval of the draft resolution, said that her Government was committed, with its G7 partners, to working together with WHO to contribute to the coordination of research and development efforts, and would support the further development of the Global Observatory with €500 000.

The representative of SWITZERLAND said that her country wished to be added to the list of sponsors of the resolution.

Health workforce and services: Item 16.1 of the agenda (documents A69/36, A69/37 and A69/37 Add.1) (continued)

- **Framework on integrated people-centred health services** (documents A69/39 and EB138/2016/REC/1, resolution EB138.R2) (continued from the fourth meeting, section 2)

The CHAIRMAN invited the Committee to consider the following revised version of the draft resolution contained in resolution EB138.R2:

The Sixty-ninth World Health Assembly,

PP1 Acknowledging Sustainable Development Goal 3 (Ensure healthy lives and promote well-being for all at all ages) including target 3.8, which addresses achieving universal health coverage, including financial risk protection, access to quality essential health care services, and access to safe, effective, quality and affordable essential medicines and vaccines for all;

PP2 Recalling resolution WHA64.9 (2011) on sustainable health financing structures and universal coverage, which urged Member States to continue investing in and strengthening health-delivery systems, in particular primary health care and services, and adequate human

¹ Transmitted to the Health Assembly in the Committee's fourth report and adopted as resolution WHA69.23.

resources for health and health information systems, in order to ensure that all citizens have equitable access to health care and services;

PP3 Reaffirming resolution WHA62.12 (2009) on primary health care, including health system strengthening, which requested the Director-General to prepare implementation plans for four broad policy directions, including putting people at the centre of service delivery **and also reaffirming the need to continue to prioritize progress on the implementation plans on the other three broad policy directions included in resolution WHA62.12 (2009): (1) dealing with inequalities by moving towards universal coverage; (2) multisectoral action and health in all policies; and (3) inclusive leadership and effective governors for health;**

PP4 Recalling resolution WHA63.16 (2010) on the WHO Global Code of Practice on the International Recruitment of Health Personnel and its recognition that an adequate and accessible health workforce is fundamental to an integrated and effective health system and for the provision of health services;

PP5 Recalling also resolution WHA64.7 (2011) on strengthening nursing and midwifery which emphasize the implementation of strategies for enhancement of interprofessional education and collaborative practice as part of people-centred care, and WHA66.23 (2013) on transforming health workforce education in support of universal health coverage;

PP6 Reaffirming resolution WHA60.27 (2007) on strengthening health information systems, which acknowledged that sound information is critical in framing evidence-based health policy and making decisions, and fundamental for monitoring progress towards internationally agreed health-related development goals;

PP7 Recalling resolutions WHA67.20 (2014) on regulatory system strengthening for medical products, WHA67.21 (2014) on access to biotherapeutic products, including similar biotherapeutic products, and ensuring their quality, safety and efficacy, WHA67.22 (2014) on access to essential medicines, ~~and~~ WHA67.23 (2014) on health intervention and technology assessment in support of universal health coverage **and WHA67.18 (2014) on traditional medicine,**

(OP1) ADOPTS the framework on integrated, people-centred health services;

(OP2) URGES Member States:

(1) to implement, as appropriate, the framework on integrated, people-centred health services at regional and country level, in accordance with national contexts and priorities;

~~(1)~~**(2)** to implement proposed policy options and interventions for Member States in the framework on integrated, people-centred health services in accordance with nationally set priorities towards achieving and sustaining universal health coverage, **including with regard to primary health care as part of health system strengthening;**

~~(2)~~**(3)** to make health care systems more responsive to people's needs, while recognizing their rights and responsibilities with regard to their own health, and engage stakeholders in policy development and implementation;

~~(3)~~**(4)** to promote coordination of health services within the health sector and intersectoral collaboration in order to address the broader social determinants of health and to ensure a holistic approach to services, including health promotion, disease prevention, diagnosis, treatment, disease-management, rehabilitation and palliative care services;

(5) to integrate where appropriate traditional and complementary medicine and modern health systems, based on national context and knowledge-based policies, while assuring the safety, quality and effectiveness of health services and taking into account a holistic approach to health;

(OP3) INVITES international, regional and national partners to take note of the framework on integrated, people-centred health services;

(OP4) REQUESTS the Director-General:

- (1) to provide technical support and guidance to Member States for the implementation, national adaptation and operationalization of the framework on integrated, people-centred health services, **paying special attention to primary health services as part of health system strengthening;**
- (2) to ensure that all relevant parts of the Organization, at headquarters, regional and country levels, are aligned, actively engaged and coordinated in promoting and implementing the framework on integrated, people-centred health services;
- (3) to perform research and development on indicators to trace global progress on integrated people-centred health services;
- (4) to report on progress **on the implementation of** ~~made in implementing~~ the framework on integrated people-centred health services to the Seventy-first and Seventy-third World Health Assemblies and at regular intervals thereafter.

The financial and administrative implications for the Secretariat of the adoption of the resolution were the same as for resolution EB138.R2 adopted by the Board.¹

The representative of LIBERIA read out the proposed amendment to operative paragraph 2(5), which read as follows: “to integrate where appropriate traditional and complementary medicine and modern health systems, based on national context and knowledge-based policies, while assuring the safety, quality and effectiveness of health services and taking into account a holistic approach to health”.

The representative of KENYA said that a system was needed for monitoring the implementation of national policies on integrated people-centred health services at all levels of the health system. Given that the implementation of those services was part of primary health care and a strengthened health system, his Government supported the inclusion of a reference within the draft resolution and framework to the use of primary health care in the implementation of the integrated people-centred health services within a strengthened health system. He asked the Secretariat to provide countries with the support necessary to ensure that the framework was fully adapted at country level.

The representative of IRAQ said that primary health care was the best approach for adopting people-centred health services. Family health evidence-based practices should be the cornerstone of the model. Community needs should be the main parameter in the presentation of primary health care. Health promotion activities needed to be invigorated and priority given to people in crisis situations, vulnerable populations and high-risk groups.

The representative of CANADA said that he accepted the new text of the draft resolution.

The draft resolution, as amended, was approved.²

¹ See document WHA69/2016/REC/1, Annex 15.

² Transmitted to the Health Assembly in the Committee’s fourth report and adopted as resolution WHA69.24.

- 3. PROGRESS REPORTS:** Item 17 of the agenda (document A69/43) [transferred from Committee A]¹

Communicable diseases

- A. Eradication of dracunculiasis (resolution WHA64.16)**

Noncommunicable diseases

- B. Sustaining the elimination of iodine deficiency disorders (resolution WHA60.21)**

Promoting health through the life course

- C. Strengthening of palliative care as a component of comprehensive care throughout the life course (resolution WHA67.19)**
D. Contributing to social and economic development: sustainable action across sectors to improve health and health equity [follow-up of the 8th Global Conference on Health Promotion] (resolution WHA67.12)
E. Reproductive health: strategy to accelerate progress towards the attainment of international development goals and targets (resolution WHA57.12)

Health systems

- F. Health intervention and technology assessment in support of universal health coverage (resolution WHA67.23)**
G. Access to essential medicines (resolution WHA67.22)
H. Access to biotherapeutic products, including similar biotherapeutic products, and ensuring their quality, safety and efficacy (resolution WHA67.21)
I. WHO strategy on research for health (resolution WHA63.21)

Corporate services/enabling functions

- J. Multilingualism: implementation of action plan (resolution WHA61.12)**

The representative of SWEDEN, speaking on behalf of the Nordic and Baltic countries Denmark, Estonia, Finland, Iceland, Latvia, Lithuania, Norway and Sweden, called for progress reports to contain clear information on their link to the results chain in the programme budget and explicit statements about their contribution towards key outcomes.

Regarding progress report C, he welcomed the policies adopted and looked forward to the development of new tools for palliative care for children. The Secretariat should also continue its work towards the introduction of palliative care monitoring mechanisms and its joint efforts with UNODC to draft legislation on the availability and accessibility of controlled medicines. Concerning progress report D, he welcomed the measures taken to strengthen the Secretariat's capacities to provide guidance and technical assistance for sustainable, multisectoral actions aimed at improving health and health equity; such efforts should continue. He asked when the casebook on country action (paragraph 28) would be published. Regarding progress report E, he expressed concern at the uneven progress and inequalities, for example, in access to contraception and safe abortion services. Urgent action was required to tackle gender-based and domestic violence against women and implement the WHO global plan of action to strengthen the role of the health systems to address interpersonal violence, in

¹ See the summary record of the General Committee, first meeting, section 2.

particular against women and girls, and against children, adopted in resolution WHA69.5. Sexual and reproductive health rights were central to the achievement of the 2030 Agenda for Sustainable Development.

The representative of THAILAND expressed great regret at the decision to consider all progress reports under one agenda item; the limited time for discussion of implementation of resolutions contrasted with the effort put into adopting them. In regard to progress report F, he welcomed the steps taken to strengthen the capacities of countries with limited resources for health intervention and technology assessment and the collaboration with other agencies. Given the large variations in progress made by countries reported in the 2015 Global Survey on Global Health Technology Assessment by National Authorities, the Secretariat should support Member States in establishing their own cost-effectiveness thresholds and devising normative guidelines to assess the attendant social and ethical impacts. Concerning progress report I, he urged the Secretariat to monitor closely the implementation of the WHO strategy on research for health. In respect of progress report A, he commended the impressive work towards the eradication of dracunculiasis.

Dr Asadi-Lari took the Chair.

The representative of MALI, speaking on behalf of the Member States of the African Region on progress report A, on the eradication of dracunculiasis, noted with concern that new cases of human and canine infections had been reported by Chad in 2016. The report referred to the work undertaken with partners, but failed to mention the efforts made by Member States in sufficient detail; that imbalance should be rectified. Member States in the Region remained concerned that cases of canine infections were noted in some of the eight countries yet to be certified as free of dracunculiasis. He welcomed the steps taken by the Secretariat to support the eradication of canine infections in Chad and efforts to prevent cross-border transmission. Further attention should, however, be paid to preventing transmission in refugee camps and countries in the midst of conflict; the Secretariat must find innovative ways to fill the US\$ 214 million funding gap for the period 2016–2020.

The representative of JAPAN welcomed the measures adopted by the Secretariat to facilitate access to essential medicines (progress report G), but called for pharmacovigilance and more appropriate use of medical products in order to prevent adverse medical effects. Scientific data on safety and efficacy must therefore be disseminated in a timely manner to all health-care providers to support that task. His Government would continue to assist the Secretariat's efforts in that area by sharing its expertise, best practices and lessons learned.

The representative of the UNITED KINGDOM OF GREAT BRITAIN AND NORTHERN IRELAND welcomed the progress made towards the eradication of dracunculiasis (progress report A) and supported the increased research focus on interrupting canine transmission of the disease. The Secretariat should facilitate cross-border dialogue and, where appropriate, use other surveillance systems to help to identify and eradicate cases of dracunculiasis. Turning to progress report H, he noted the growing number of poor quality and fake medicines entering the market and urged Member States to remain vigilant. The Secretariat must strive to change the perception that the process of WHO pre-qualification for medicines, vaccines and diagnostic tests was time-consuming and expensive, particularly in the case of medications that had already been approved by a recognized international agency. Some form of agreement on an accelerated procedure for pre-qualification should therefore be established at the earliest opportunity.

The representative of SRI LANKA acknowledged the work on sustaining the elimination of iodine deficiency disorders (progress report B); decisive action by his Government had resulted in very low rates. Regarding progress report D, he welcomed the Secretariat's steps to promote

sustainable action across sectors and raise awareness of the need to harmonize policy decisions in different sectors in order to improve health and health equity. Sri Lanka had recently adopted various policy measures to improve multisectoral action on health, including the establishment of a national health development network and council. However, the country continued to face challenges, such as demographic and epidemiological transitions and unhealthy lifestyles. In that connection, he thanked the Secretariat for its support during the mission of the United Nations Inter-Agency Task Force on the Prevention and Control of Non-Communicable Diseases to Sri Lanka in 2015 and urged it to provide the country with additional tools and guidelines to monitor future progress.

The representative of KENYA said that his country remained committed to dracunculiasis eradication and had adopted numerous measures to halt transmission of the disease. The last known indigenous case in Kenya had been reported in 1994, with the last imported case in 2005. Pre-certification activities had started in 2006 and it was hoped that the country would be certified free of dracunculiasis by the end of 2016.

The representative of the REPUBLIC OF KOREA expressed appreciation for the Secretariat's efforts to strengthen access to essential medicines and biotherapeutic products. Her Government had taken various steps to detect shortages and stock-outs of essential medications, including the establishment of a medicine-shortage management system, and remained committed to cooperating with other Member States to harmonize regulations of biotherapeutic products.

The representative of CHINA, referring to progress report G on access to essential medicines, said that her Government had established an indicator mechanism to monitor the implementation of resolution WHA67.22 (2014) at the national level. In respect of progress report J, she stressed the importance of language diversity to the work of WHO and called on the Secretariat to provide further information on the budget allocated for the recruitment of translation and language service staff.

The representative of SENEGAL welcomed the considerable drop in the number of cases of dracunculiasis, but called for additional steps to raise awareness of the disease among the general public in disease-endemic areas and ensure universal access to potable water. In order to eradicate dracunculiasis by 2020, greater efforts must be made to take account of the threats and constraints facing countries affected by the disease and provide those States with the appropriate human, material and financial support, where necessary.

The representative of the UNITED STATES OF AMERICA urged the Secretariat to continue promoting the detection and prevention of dracunculiasis, particularly in Chad where the number of cases of canine infections remained high. Regarding palliative care, he welcomed the progress made towards the implementation of resolution WHA67.19 and efforts made to integrate palliative care into all aspects of medical treatment. Further collaboration between WHO and the International Narcotics Control Board, the United Nations Commission on Narcotic Drugs and the Economic and Social Council would be required to facilitate appropriate access to controlled narcotics required for the relief of pain and suffering of palliative care patients. As to reproductive health, he supported the work undertaken at an international level to help Member States to strengthen and increase access to their respective national reproductive health services, particularly in the light of the recent Zika virus outbreak. In respect of research on health, he called for WHO to prioritize the translation of research into practical actions, establish the necessary research standards, manage research in areas of unmet needs and promote essential research in low- and middle-income countries.

The representative of MALAWI, speaking on behalf of the Member States of the African Region on progress report E, welcomed the steps taken to accelerate progress towards the attainment of target 3.7 of the Sustainable Development Goals, on universal access to reproductive health services. However, progress remained uneven across countries and regions. For example, reproductive

health continued to represent a major public health challenge in the African Region, with sub-Saharan Africa accounting for 66% of the world's maternal deaths. He therefore urged the Secretariat and WHO's development partners to continue their efforts to overcome the logistic, economic, cultural and political barriers to sexual and reproductive health.

The representative of IRAQ said that a multisectoral approach was vital in combating iodine deficiency and other micronutrient deficiencies. With regard to improving health and health equity, special attention should be paid to combating social determinants of health as part of efforts to ensure sustainable action across sectors to improve health and health equity. Concerning palliative care, particular emphasis should be placed on family health as a component of providing comprehensive care throughout the life-course. In respect of reproductive health care, health services should consider the issue of gender, equity and equality more effectively and take into account technological advances in health care when moving towards universal health coverage. Access to, and the effective use of, essential medicines should form the cornerstone of any universal health care strategy. Importance should also be placed on the role of research in health.

The representative of CHAD said that, pending the results of operational research, steps had been taken to quarantine dogs in the light of the recent canine infections of dracunculiasis in the country. His Government remained fully committed to the monitoring, prevention and eradication of dracunculiasis and called for further multisectoral action to combat the disease.

The representative of INDONESIA, referring to reports G and H, said that access to medicines and vaccines was a priority in Indonesia that was reflected in a national medicine policy that was implemented according to good governance principles. Decisions had been taken about which biotherapeutic products could be used within the national health insurance scheme, and a national regulatory framework for biopharmaceuticals had been established. He urged WHO to continue its work in ensuring the accessibility of global essential medicines and vaccines for the Expanded Programme on Immunization and its trilateral collaboration with WTO and WIPO, through which it could provide further information to Member States on how policies on trade, health and intellectual property interacted with each other.

The representative of TIMOR-LESTE, referring to progress report G, said that, in his country, expenditure on pharmaceuticals was already the largest health care cost, at a time when adequate funding remained a challenge. The Government had established a body to procure and supply medicines and a national medicines regulatory authority. Despite progress in improving access to medicines, health ministry still required significant technical and expert support from the Regional Office for South-East Asia and the WHO country office.

The representative of MALDIVES, referring to progress report B, welcomed the commissioning of an updated review on the effects of iodine supplementation on women during the preconception, pregnancy and postpartum periods. Despite progress, continued efforts were needed to eliminate iodine deficiency disorders, especially among vulnerable groups. He stressed the need to establish a population-level baseline for dietary salt intake, educate the public, and promote behavioural change both to reduce salt intake and to use iodized salt. Useful approaches included reducing salt intake in processed foods, and establishing national committees to ensure that dietary salt reduction and salt iodization policies were compatible.

The representative of CAMEROON, speaking on behalf of the Member States of the African Region on access to essential medicines, welcomed progress report G but said that it should have dealt with the challenge of implementing a plan to develop the pharmaceutical industry in Africa. Efforts to secure access to high-quality essential medicines must continue.

The representative of TOGO, speaking on behalf of the Member States of the African Region on progress report F, acknowledged WHO's contribution to improving access to prevention and treatment services by bringing together mobile telephone operators and the health and development community, and called for continuation of that work. Countries needed information about the situation of e-health in the Region in order to take evidence-based decisions. Major challenges that remained in the Region included ensuring that universal health coverage applied to the informal sector and establishing regional- and national-level health-care databases. Levels of technical support and financing varied greatly throughout the Region. Member States in the Region would benefit if partners took a more harmonized approach under the leadership of WHO. Universal health coverage was an important part of achieving Sustainable Development Goal 3.

The representative of MONACO, referring to progress report J, said that more should be done to ensure a better linguistic balance in the Secretariat. Less than a third of the material available in English on the WHO website was also available in French, with an even smaller proportion available in the other official languages. It was particularly regrettable that tools for the prevention of noncommunicable diseases were almost exclusively in English, despite the stated intention to make those tools the primary reference for national focal points on such diseases. Translating documents, particularly technical ones, as soon as possible into all the official languages would contribute to sustainable development on health-related matters.

The observer of CHINESE TAIPEI, referring to progress report C, said that provisions relating to palliative care were included in the health insurance system of Chinese Taipei. Legislation had been enacted in 2016 to safeguard palliative care provision and patient autonomy.

The observer of the INTERNATIONAL FEDERATION OF RED CROSS AND RED CRESCENT SOCIETIES, referring to progress report C, deprecated the lack of access globally and in particular in Africa to palliative care. Her organization ran community- and home-based palliative care programmes, but much more was needed.

The representative of the UNION FOR INTERNATIONAL CANCER CONTROL, speaking at the invitation of the CHAIRMAN and referring to progress report C, said that she welcomed the efforts to create new guidance, tools and training. Under a joint global programme developed by UNODC, WHO and her organization on improving access to controlled medicines for pain and palliative care, work to implement the provisions of resolution WHA67.19 had begun in Ghana, Timor-Leste and the Democratic Republic of Congo. She called for other countries besides existing donors to provide funds to that end. Palliative care should be included as part of national plans for universal health coverage. All countries should adopt national strategies for palliative care that included the training of health professionals and access to essential palliative care medicines. The next progress report should be submitted to the Seventy-first World Health Assembly in 2018.

The representative of the WORLDWIDE HOSPICE PALLIATIVE CARE ALLIANCE, speaking at the invitation of the CHAIRMAN and referring to progress report C, said that, despite the provisions of resolution WHA67.19, most governments did not include palliative care in health care policies and legislation. Although progress had been made since that resolution passed, there was still a lack of political will and public financing, and much work remained to be done on educating the health workforce. To make further progress, donor countries should make funds available for the full implementation of the resolution. All countries should adopt national strategies on palliative care as part of universal health coverage. The next progress report on the subject should be presented to the Seventy-first World Health Assembly.

The representative of the INTERNATIONAL FEDERATION FOR MEDICAL AND BIOLOGICAL ENGINEERING, speaking at the invitation of the CHAIRMAN and on behalf of the International Federation of Hospital Engineering, referred to progress report F. Health technology assessment objectives could be successfully achieved if government policies were based on the knowledge of experts such as biomedical engineers and medical physicists.

The representative of HEALTH TECHNOLOGY ASSESSMENT INTERNATIONAL, speaking at the invitation of the CHAIRMAN and referring to progress report F, said that the success of health technology assessment depended on strategies that were based on the expertise of multidisciplinary teams and that took account of the views of stakeholders. Health technology assessment agencies should be established to inform and harmonize the processes of market access, reimbursement, provision and prescription of health technologies.

The representative of the GLOBAL HEALTH COUNCIL, speaking at the invitation of the CHAIRMAN and referring to progress report G, said that there was rarely a single reason behind the lack of access to innovative and life-saving technologies, especially those relevant to poverty-related and neglected diseases. The issue should be viewed in parallel with factors that could facilitate greater access, such as enabling regulatory and policy environments, well-functioning markets, engagement of local communities and affordable pricing.

The ASSISTANT DIRECTOR-GENERAL (HIV/AIDS, Tuberculosis, Malaria and Neglected Tropical Diseases), referring to comments on progress report A, reaffirmed the good progress towards eradicating dracunculiasis, with only two confirmed cases reported between January and April 2016, compared to four cases for the same period during the previous year. The target of eradicating transmission by the end of 2015 had not been met, but it was within reach, as no case had been reported in Ethiopia, Mali or South Sudan in the first four months of 2016. Following the finding of *Dracunculus medinensis* infection in dogs in African countries, appropriate research was being conducted. The Secretariat continued to be committed to the implementation of resolution WHA64.16 (2011).

Referring to progress report E, the ASSISTANT DIRECTOR-GENERAL (Family, Women's and Children's Health) said that the comments by Member States were consistent with those in the discussions of the resolutions adopted during the current Health Assembly pertaining to women's, children's and adolescents' health; the global health sector strategy on sexually transmitted infections; and the plan of action to strengthen the role of the health system to address interpersonal violence, in particular against women and girls, and against children.

Regarding progress report B, the DIRECTOR (Nutrition for Health and Development) reaffirmed the progress made in reducing iodine deficiency throughout the world but he recalled the caveat in the report about the limitations of the data; it was not possible to assess the iodine status of other sections of the population than school-aged children. The preferred strategy for controlling iodine deficiency disorders remained universal salt iodization. To ensure that that strategy was compatible with strategies to reduce sodium intake, adequate monitoring of sodium and iodine consumption at the country level was required. Iodine concentrations in salt should be adjusted by individual countries according to local data on salt intake.

The representative of INDIA, referring to progress report H, recalled that in resolution WHA69.21 (2014) the Health Assembly had requested the Director-General to convene the Expert Committee on Biological Standardization in order to update the 2009 guidelines on evaluation of biotherapeutic products, taking into account technological advances and considering national regulatory needs and capacities, and to report on the update to the Executive Board. He sought clarification, as there was no reference to that request in the progress report.

The DIRECTOR (Essential Medicines and Health Products) said that a new document had been developed for consideration by the Expert Committee on Biological Standardization later in 2016.

The Committee noted the progress reports.

Dr Phusit Prakongsai resumed the Chair.

4. HEALTH SYSTEMS (resumed)

Addressing the global shortages of medicines, and the safety and accessibility of children's medication: Item 16.4 of the agenda (document A69/42) (continued from the fifth meeting)

The CHAIRMAN drew attention to the following revised version of the draft resolution that had been introduced at the fifth meeting, on addressing the global problem of medicines shortages:

The Sixty-ninth World Health Assembly,

PP1 Having considered the report on global shortages of medicines and the safety and accessibility of children's medicines;

PP2 Recommends to the Sixty-ninth World Health Assembly the adoption of the following resolution:

PP3 Recalling the World Health Assembly resolutions WHA67.22 on access to essential medicines, WHA60.20 on better medicines for children, WHA67.20 on Regulatory system strengthening, WHA67.21 access to biotherapeutic products, including similar biotherapeutic products, and ensuring their quality, safety and efficacy, WHA61.21 on global strategy and plan of action on public health, innovation and intellectual property, WHA65.19 on substandard/spurious/falsely-labelled/falsified/counterfeit (SSFFC) medical products, WHA65.17 on the global vaccines action plan, WHA68.7 on the global action plan on antimicrobial resistance, ~~and~~ WHA67.25 on antimicrobial resistance, ~~as well as resolutions WHA64.9 on sustainable health financing structures and universal coverage, and also, recalling the Resolution A/HRC/RES/12/24 from the Human Rights Council on access to medicines;~~

PP4 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 [~~reference (A67/81)~~];

PP5 Recognizing that the continuous supply of quality, safe, effective and affordable medicines is one of the building blocks of every well-functioning health system, which requires a reliable supply chain: and noting ~~reports~~ of global medicines shortages¹ and stockouts² that also infringe upon the patients right to the enjoyment of the highest attainable standard of health as envisaged by the WHO Constitution; undermine the attainment of public health prevention

¹ ~~A working definition for the purposes of this resolution of medicine shortage refers to a situation where there is insufficient quantity of a particular medicine relative to usual need at any point/s in the supply chain (from manufacturer to facility where patient receives treatment). Stockouts~~ Shortages that occur at manufacturer or wholesaler level are serious since they are more likely to lead to many patients receiving no treatment if not urgently addressed (Interagency Working Group).

² ~~A working definition for the purposes of this resolution of medicine stockout refers to a situation where there is no stock of a particular medicine at any point/s in the supply chain (from manufacturer to facility where patient receives treatment). Stockouts can also occur at any point in the supply chain however those stockouts that occur at manufacturer or wholesaler level are serious since they are more likely over time to lead to many patients receiving no treatment (Interagency Working Group).~~

and treatment goals; and threaten governments' ability to scale up services towards achieving universal health coverage as well as their ability to adequately respond to outbreaks and health emergencies;

PP6 Recalling Goal 3, Target 8 of the Agenda 2030 for Sustainable Development, which includes, ~~inter alia,~~ the commitment to achieve universal health coverage, financial risk protection, access to quality essential health care services ~~primary health care services~~ and access to safe, effective, quality and affordable medicines and vaccines for all ~~by 2030~~;

PP7 Acknowledging that Agenda 2030, supports the research and development of vaccines and medicines for the communicable and noncommunicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use to the full the provisions in the agreement on Trade-Related Aspects on Intellectual Property Rights regarding flexibilities to protect public health, and, in particular, provide access to medicines for all (A/RES/70/1 target 3.b);

PP8 ~~Noting that the challenges related to medicine shortages and stockouts are widespread, affecting medicine manufacturers, procurement agencies and countries at every economic level, and they appear to be escalating in severity, and the factors that affect the non-availability of medicines **include problems with the manufacture of the medicine (including inability to source the active pharmaceutical ingredient), regulatory processes, challenges** can be categorised into three areas: problems with the manufacture of the medicine, challenges with the procurement of medicines, **selective marketing strategies** and problems with the supply chain which result in medicines being unavailable when patients access care; therefore interventions to address weaknesses in all three areas are critical to ensure that medicines are available at the point of care;~~**PP8** Noting that the challenges related to medicines shortages affect access to medicines, are complex and widespread, increasing in frequency, and affect citizens, procurement agencies and countries at every level of development and that there is insufficient information to determine the magnitude and specific characteristics of the problem;

PP9 ~~Aware that the shortages of medicines is **are** a global problem, **and** 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;~~

PP10 Noting also that the implications of these shortages in the case of infectious diseases ~~goes beyond the individual patient and~~ impacts public health as a shortage/stockout of antibiotics, antituberculosis drugs, antiretrovirals, antimalarials ~~and~~ vaccines may result in the spread of infection beyond the individual patient;

PP101 Considering that there is a need for improved international collaboration on the management of shortages of medicines ~~given that medicines shortages may increase risks of SSFFC medical products entering the supply chain;~~

PP12 ~~Concerned about the challenges that shortages of medicines pose to Member States, in relation to **progress towards** ensuring universal access to healthcare, research and development, rational use of medicines, and that the financial sustainability of health systems can be affected by technological pressures **arising from new** caused by high cost medicines; **and noting that investment in research and development for new products may help develop alternative treatments,** and aware that urgent patient-centred action is needed by the international community, Member States and relevant actors in health systems;~~

1. URGES Member States;¹

(OP1) to develop strategies that may be used to forecast, avert or reduce shortages/stockouts, in accordance with adapted to national priorities and contexts, including:

- (a) to implement effective notification systems that allow remedial ~~intervention~~ measures to avoid ~~circumvent~~ medicine shortages;
- (b) to ensure that best practices for medicines procurement, distribution and contract management processes are in place to mitigate the risk of shortages;
- (c) to develop and/or strengthen systems that are capable of monitoring medicine supply, demand, availability and alerting procurement departments to possible medicine availability problems;
- (d) to strengthen institutional capacity to ensure sound financial management of procurement systems, to prevent funding shortfalls for medicines;
- ~~(5) to promote, review and strengthen programmes, public policies, and~~ **develop responsive regulatory frameworks, and systems and authorities that provide timely and efficient registration of new medicines, new age-appropriate formulations, generics, and post-approval supplements, thereby promoting access to medicines and furthermore to align policy frameworks to be responsive to medicines that are at risk of being unavailable at the point of care; through the appropriate regulatory strategies;**
- (e) to urge Member States, when confronted with shortages, to prioritize, in the case of shortages, the health needs of the most affected to focus on health rights of everyone especially vulnerable groups and to ensure these groups have timely access to medicines in shortage;
- (7) to seek ~~consider measures~~ to make medicines more affordable through the implementation of various strategies to manage prices such as ~~addressing excessive supply chain mark-ups, elimination of taxes and import tariffs,~~ price negotiations/regulation, voluntary/compulsory licences, ~~consistent with the Global Strategy and Plan of Action for Public Health Innovation and Intellectual Property,~~ in order to decrease prices of medicines in shortage;
- (8) to support reliable and sustainable supply of quality, off-patent medicines through adequate pricing and through effective enforcement of drug regulatory and supply chain security standards.

(OP1.32) to advance gradually regional and international cooperation in support of integration of national notification systems including but not limited to sharing of best practices, training for human capacity building through regional and subregional structures where necessary with a view of establishing an international notification system for essential medicine shortages and stockouts;

(OP223) CALLS upon manufacturers (active pharmaceutical ingredient and formulation), wholesalers, global, and regional procurement agencies and other relevant stakeholders to contribute to global efforts to address the challenges of medicines shortages, including through participation in notification systems;

OP3.2. REQUESTS the Director-General:

(1) to develop technical definitions as needed for medicines shortages and stock outs, taking due account of access and affordability in consultation with Member State experts in keeping with WHO established processes and to submit a report on the definitions to the Seventieth World Health Assembly through the Executive Board;

¹ And, regional economic integration organizations, as appropriate.

- (2) to develop an assessment of the magnitude and nature of the problem of shortages of medicines;
- (3~~4~~) to support Member States in addressing the global challenges of medicines shortages by developing a global medicine shortage notification system; which would ~~may~~ include information to better detect and understand the causes of medicines shortages;
- ~~(2) — to propose global best practices for the notification and management of shortages, (including data standards, database management), and management of shortages and regulatory/legislative strategies (including measures to address mark-ups, taxes, tariffs, voluntary licenses and the full use of TRIPS flexibilities in accordance with the WHO Global Strategy and Plan of Action on Public Health Innovation and Intellectual Property) to avoid and~~ to minimize the impact of shortages ~~where appropriate;~~
- ~~(3) — to develop an assessment of the magnitude and nature of the problem of shortages of medicines, including the relative contributions of factors such as: market supply system failures, obstacles to access and availability, and pressures, manufacturing and distribution challenges, and recommended solutions, to address the most important factors identified;~~
- ~~(4) — to identify medicines that are at particular risk of being in short supply and develop strategies to facilitate ensure their availability at an affordable price in collaboration with global partners;~~
- ~~(5) — to prioritize, the development of new or updated procurement and supply chain guidelines for health products, to support the effective functioning of health systems and minimize the risk of shortages;~~
- ~~(6) — to work with global partners to strengthen systems for supply chain management for health products;~~
- ~~(7) — to support Member States in the implementation of surveillance systems that will monitor and report supply and demand of medicines, using standardized formats throughout the supply chain, to predict needs and shortages, and that also reduce the risk of SSFFC medical products entering the supply chain;~~
- ~~(8) — to continue to support the Member State mechanism on SSFFC medical products;~~
- ~~(98) — (4) to report on progress and outcome of the implementation of this resolution to the Seventy-first session of the World Health Assembly.~~

The CHAIRMAN announced that a further revision of the draft resolution had just been distributed to the Committee.

The representative of SOUTH AFRICA explained that an informal working group had further revised the above text. The revision read:

The Sixty-ninth World Health Assembly,

PP1 Having considered the report on global shortages of medicines and the safety and accessibility of children's medicines;

PP2 Recommends to the Sixty-ninth World Health Assembly the adoption of the following resolution:

PP3 Recalling the World Health Assembly resolutions WHA67.22 on access to essential medicines, WHA60.20 on better medicines for children, WHA67.20 on Regulatory system strengthening, WHA67.21 access to biotherapeutic products, including similar biotherapeutic products, and ensuring their quality, safety and efficacy, WHA61.21 on global strategy and plan of action on public health, innovation and intellectual property, WHA65.19 on substandard/spurious/falsely-labelled/falsified/counterfeit (SSFFC) medical products,

WHA65.17 on the global vaccines action plan, WHA68.7 on the global action plan on antimicrobial resistance, ~~and~~ WHA67.25 on antimicrobial resistance, WHA64.9 on sustainable health financing structures and universal coverage, and Resolution A/HRC/RES/12/24 from the Human Rights Council on access to medicines;

PP4 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;

PP5 Recognizing that the continuous supply of quality, safe, effective and affordable medicines is one of the building blocks of every well-functioning health system, which requires a reliable supply chain: and noting reports of global medicines shortages and stockouts that also infringe upon the right to the enjoyment of the highest attainable standard of health as envisaged by the WHO Constitution; undermine the attainment of public health prevention and treatment goals; and threaten governments' ability to scale up services towards achieving universal health coverage as well as their ability to adequately respond to outbreaks and health emergencies;

PP6 Recalling Goal 3, Target 8 of the Agenda 2030 for Sustainable Development, which includes the commitment to achieve universal health coverage, financial risk protection, access to quality essential health care services and access to safe, effective, quality and affordable medicines and vaccines for all;

PP7 Acknowledging that Agenda 2030, supports the research and development of vaccines and medicines for the communicable and noncommunicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use to the full the provisions in the agreement on Trade-Related Aspects on Intellectual Property Rights regarding flexibilities to protect public health, and, in particular, provide access to medicines for all (A/RES/70/1 target 3.b);

PP8 Noting that the challenges related to medicines shortages affect access to medicines, are complex and widespread, increasing in frequency, and affect citizens, procurement agencies and countries at every level of development and that there is insufficient information to determine the magnitude and specific characteristics of the problem;

PP9 Noting also that the implications of these shortages in the case of infectious diseases impacts public health as a shortage/stockout of antibiotics, antituberculosis drugs, antiretrovirals, antimalarials and vaccines may result in the spread of infection beyond the individual patient;

PP10 Considering that there is a need for improved international collaboration on the management of shortages of medicines;

1. URGES Member States;¹

(OP1) to develop strategies that may be used to forecast, avert or reduce shortages/stockouts, in accordance with national priorities and contexts, including:

- (a) to implement effective notification systems that allow remedial measures to avoid medicine shortages;
- (b) to ensure that best practices for medicines procurement, distribution and contract management processes are in place to mitigate the risk of shortages;
- (c) to develop and/or strengthen systems that are capable of monitoring medicine supply, demand, availability and alerting procurement departments to possible medicine availability problems;
- (d) to strengthen institutional capacity to ensure sound financial management of procurement systems, to prevent funding shortfalls for medicines;

¹ And, regional economic integration organizations, as appropriate.

(e) to prioritize, in the case of shortages, the health needs of the most affected groups and to ensure these groups have timely access to medicines;

(OP1.2) to advance gradually regional and international cooperation in support of national notification systems including but not limited to sharing of best practices, training for human capacity building through regional and subregional structures where necessary;

(OP2) CALLS upon manufacturers, wholesalers, global, and regional procurement agencies and other relevant stakeholders to contribute to global efforts to address the challenges of medicines shortages, including through participation in notification systems;

OP3 2. REQUESTS the Director-General:

- (1) to develop technical definitions as needed for medicines shortages and stock outs, taking due account of access and affordability in consultation with Member State experts in keeping with WHO established processes and to submit a report on the definitions to the Seventieth World Health Assembly through the Executive Board;
- (2) to develop an assessment of the magnitude and nature of the problem of shortages of medicines;
- (3) to support Member States in addressing the global challenges of medicines shortages by developing a global medicine shortage notification system; which would include information to better detect and understand the causes of medicines shortages;
- (4) to report on progress and outcome of the implementation of this resolution to the Seventy-first session of the World Health Assembly.

The representative of the UNITED STATES OF AMERICA welcomed the draft resolution. It was important to distinguish the issue of shortages of medicines from the broader challenges of access, pertaining to affordability and general availability. Shortages most frequently affected products that were old, off-patent or difficult to formulate and had a tightly-defined shelf life, few or one sole manufacturer, for example in the case of sterile injectables. There was poor availability and quality of data on actual demand; inadequate management practices in procurement and the supply chain, combined with large tender contracts that did not sufficiently define quality standards but whose sole emphasis was on obtaining the lowest prices; and inadequate incentives for manufacturers. The revised text provided an excellent basis for focused WHO action, and he was pleased to support it.

The representative of COLOMBIA expressed support for the draft resolution. He proposed amending the ninth preambular paragraph to include a reference to antiparasitic medicines.

The representative of THAILAND endorsed the draft resolution and wished to be included on the list of cosponsors.

The representative of IRAQ proposed a series of further amendments to the text. Throughout the document, he proposed adding “and vaccines” to all mentions of medicines, to read “shortages of medicines and vaccines”. In the ninth preambular paragraph, he proposed adding after the word “antimalarials” the phrase “, medicines to treat neglected tropical diseases”. He proposed that, in the tenth preambular paragraph, adding the words “and responsibility” after “collaboration” as that was a delicate issue. In the first operative paragraph, he proposed amending subparagraph (a) by replacing “remedial” by “pharmaceutical”; amending subparagraph (b) by the addition of “and vaccines” after “medicines”; amending subparagraph (c) similarly by twice replacing “medicine” by “medicine and vaccines” to read “to develop and/or strengthen systems that are capable of monitoring and evaluating medicines and vaccines supply, demand and availability and alerting procurement departments to possible medicine and vaccine availability and utilization problems”; amending paragraph 1(d) to read

“ to strengthen personnel with institutional capacity-building to ensure sound financial management of procurement and management systems, to prevent funding shortfalls for medicines and vaccines”; and amending paragraph 1(e) to read “to prioritize, in the case of shortages, the health needs of vulnerable groups ensuring that these groups have timely access to medicines and vaccines”. In operative paragraph 1.2 he proposed amending the text to read “to upgrade gradually regional and international cooperation in support of national notification systems including but not limited to sharing of best practices and buys, training for human capacity building through regional and subregional structures where necessary”. In operative paragraph 2, he proposed adding the word “vaccines”, so that the text would read “CALLS upon manufacturers, wholesalers, global, and regional procurement agencies and other relevant stakeholders to contribute to global efforts to address the challenges of medicines and vaccines shortages, through participation in notification systems”. He proposed adding a new request to the Director-General in operative paragraph 3.2(1) to read “to develop technical definitions as needed for medicines and vaccines shortages and stock-outs, taking due account of access and affordability in consultation with Member State experts in keeping with WHO established processes and to submit a progress report on the definitions to the Seventieth World Health Assembly through the Executive Board”, and amending operative paragraph 3.2(3) to read “to support Member States in addressing the global challenges of medicines and vaccine shortages by developing a global medicine shortage notification system; which would include effective information systems to better detect and understand the causes of medicines shortages, to effectively support their collective work plans.”

The representative of ZIMBABWE expressed support for the revised draft resolution. His Government was willing to cosponsor the resolution in its current form.

The representative of SOUTH AFRICA said that it would be difficult to make changes to the text at such a late stage, given existing time constraints. However, he understood that the issue of vaccines was relevant, and that the intent of the draft resolution was to cover both medicines and vaccines. He suggested that the title could be amended to “medical products”. It would also be possible to add a reference in the ninth preambular paragraph to “antiparasitics” and “medicines for neglected tropical diseases”, as those amendments would not constitute a substantive change to the text. Other proposed amendments would require further consultation.

The meeting was suspended at 17:10 and resumed at 17:25.

The representative of SOUTH AFRICA said that the informal working group had agreed that the title of the resolution would be amended to read “Addressing the global shortages of medicines and vaccines, and the safety and accessibility of children’s medication” and that the text of the ninth preambular paragraph would be amended to read “Noting also that the implication of these shortages in the case of infectious diseases impacts public health as a shortage/stockout of, antibiotics, antituberculosis drugs, antiretrovirals, antimalarials, antiparasitics and medicines for neglected diseases and vaccines may contribute to the spread of infection beyond the individual patient”.

The representative of the UNITED STATES OF AMERICA remarked that the informal working group had agreed that the ninth preambular paragraph should refer to neglected *tropical* diseases. He welcomed the engagement of representatives with the issues at hand, but advised that amendments should preferably be submitted in advance, rather than during the Committee’s meeting.

The representative of SOUTH AFRICA confirmed that the text should indeed refer to “neglected tropical diseases”.

The draft resolution, as amended, was approved.¹

5. FOURTH REPORT OF COMMITTEE B (document A69/75)

The SECRETARY of Committee B 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 17:35

¹ Transmitted to the Health Assembly in the Committee's fourth report and adopted as resolution WHA69.25.

² See page 385.

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

[A69/67 – 25 May 2016]

The Committee on Credentials met on 24 May 2016. Delegates of the following Member States were present: Georgia; Haiti; Kenya; Liberia; Madagascar; Poland; Spain; Tonga.²

The Committee elected the following officers: Ms Katarzyna Rutkowska (Poland) – Chairman; and Dr Bernice Dahn (Liberia) – 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 proposed that the World Health Assembly should recognize their validity.

States whose credentials it was considered should be recognized as valid (see fourth paragraph above and decision WHA69(6)):

Afghanistan; Albania; Algeria; Andorra; Angola; Antigua and Barbuda; 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; Denmark; Djibouti; Dominican Republic; Ecuador; Egypt; El Salvador; Equatorial Guinea; Eritrea; Estonia; Ethiopia; Fiji; Finland; France; Gabon; Georgia; Germany; Ghana; Greece; Grenada; Guatemala; Guinea; 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; Lithuania; Luxembourg; Madagascar; Malawi; Malaysia; Maldives; Mali; Malta; Marshall Islands; Mauritania; Mauritius; Mexico; Micronesia (Federated States of); Monaco; Mongolia; Montenegro; Morocco; Mozambique; Myanmar; Namibia; Nepal; Netherlands; New Zealand;

¹ Approved by the Health Assembly at its sixth and seventh plenary meetings.

² See decision WHA69(1).

Nicaragua; Niger; Nigeria; Norway; Oman; Pakistan; Palau; Panama; Papua New Guinea; Paraguay; Peru; Philippines; Poland; Portugal; Qatar; Republic of Korea; Republic of Moldova; Romania; Russian Federation; Rwanda; Saint Kitts and Nevis; Saint Vincent and the Grenadines; Samoa; San Marino; Sao Tome and Principe; Saudi Arabia; Senegal; Serbia; Seychelles; Sierra Leone; Singapore; Slovakia; Slovenia; Solomon Islands; Somalia; South Africa; South Sudan; Spain; Sri Lanka; Sudan; Suriname; Swaziland; Sweden; Switzerland; Syrian Arab Republic; Tajikistan; Thailand; the former Yugoslav Republic of Macedonia; Timor-Leste; Togo; Tonga; Tunisia; Turkey; Turkmenistan; Tuvalu; Uganda; Ukraine; United Arab Emirates; United Kingdom of Great Britain and Northern Ireland; United Republic of Tanzania; United States of America; Uruguay; Uzbekistan; Vanuatu; Venezuela (Bolivarian Republic of); Viet Nam; Yemen; Zambia; Zimbabwe.

GENERAL COMMITTEE¹

Report²

[A69/68 – 26 May 2016]

Election of Members entitled to designate a person to serve on the Executive Board

At its meeting on 25 May 2016, the General Committee, in accordance with Rule 100 of the Rules of Procedure of the World Health Assembly, drew up the following list of 12 Members, in the English alphabetical order, to be transmitted to the Health Assembly for the purpose of the election of 12 Members to be entitled to designate a person to serve on the Executive Board: Algeria, Bahrain, Bhutan, Burundi, Colombia, Fiji, Jamaica, Libya, Mexico, Netherlands, Turkey and Viet Nam.

In the General Committee's opinion these 12 Members would provide, if elected,³ a balanced distribution of the Board as a whole.

COMMITTEE A

First report²

[A69/66 – 25 May 2016]

Committee A held its first meeting on 23 May 2016 under the chairmanship of Mr Martin Bowles (Australia).

In accordance with Rule 34 of the Rules of Procedure of the World Health Assembly, the Committee elected Ms Taru Koivitsu (Finland) and Mr Nickolas Steele (Grenada) as Vice-Chairmen and Ms Aishah Samiya (Maldives) as Rapporteur.

¹ See decision WHA69(4) for the establishment of the Committee.

² Approved by the Health Assembly at its seventh plenary meeting.

³ The Health Assembly considered the list at its seventh plenary meeting and elected the 12 Members (see decision WHA69(7)).

It was decided to recommend to the Sixty-ninth World Health Assembly the adoption of one decision relating to the following agenda item:

11. WHO reform

11.2 Member State consultative process on governance reform

Decision based on the agreed recommendations of the Open-ended Intergovernmental Meeting on Governance Reform (Geneva, 8 and 9 March 2016 and 28 and 29 April 2016) [WHA69(8)].

Committee A held its third meeting on 24 May 2016 under the chairmanship of Mr Martin Bowles (Australia).

It was decided to recommend to the Sixty-ninth World Health Assembly the adoption of one resolution relating to the following agenda item:

13. Promoting health through the life course

13.2 Health in the 2030 Agenda for Sustainable Development [WHA69.1]

Strengthening essential public health functions in support of the achievement of universal health coverage [WHA69.1].

Second report¹

[A69/70 – 26 May 2016]

Committee A held its fourth meeting on 25 May 2016 under the chairmanship of Mr Martin Bowles (Australia).

It was decided to recommend to the Sixty-ninth World Health Assembly the adoption of one decision relating to the following agenda item:

14. Preparedness, surveillance and response

14.9 Reform of WHO's work in health emergency management: WHO Health Emergencies Programme [WHA69(9)].

Third report²

[A69/72 – 27 May 2016]

Committee A held its ninth meeting on 26 May 2016 under the chairmanship of Ms Taru Koivisto (Finland).

¹ Approved by the Health Assembly at its seventh plenary meeting.

² Approved by the Health Assembly at its eighth plenary meeting.

It was decided to recommend to the Sixty-ninth World Health Assembly the adoption of two resolutions relating to the following agenda item:

13. Promoting health through the life course
 - 13.3 Operational plan to take forward the Global Strategy for Women's, Children's and Adolescents' Health

Committing to implementation of the Global Strategy for Women's, Children's and Adolescents' Health [WHA69.2]
 - 13.4 Multisectoral action for a life course approach to healthy ageing: draft global strategy and plan of action on ageing and health

Global strategy and action plan on ageing and health 2016–2020: towards a world in which everyone can live a long and healthy life [WHA69.3].

Fourth report¹

[A69/73 – 28 May 2016]

Committee A held its tenth and eleventh meetings on 27 May 2016 under the chairmanship of Mr Martin Bowles (Australia) and Ms Taru Koivisto (Finland).

It was decided to recommend to the Sixty-ninth World Health Assembly the adoption of two decisions and three resolutions relating to the following agenda items:

13. Promoting health through the life course
 - 13.5 Health and the environment: draft road map for an enhanced global response to the adverse health effects of air pollution [WHA69(11)]
 - 13.6 Role of the health sector in the sound management of chemicals

The role of the health sector in the Strategic Approach to International Chemicals Management towards the 2020 goal and beyond [WHA69.4].
12. Noncommunicable diseases
 - 12.2 Report of the Commission on Ending Childhood Obesity [WHA69(12)]
 - 12.3 Draft global plan of action on violence

WHO 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 [WHA69.5]
 - 12.4 Prevention and control of noncommunicable diseases: responses to specific assignments in preparation for the third High-level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases in 2018 [WHA69.6].

Fifth report¹

[A69/76 – 30 May 2016]

Committee A held its twelfth and thirteenth meetings on 28 May 2016 under the chairmanship of Mr Martin Bowles (Australia).

¹ Approved by the Health Assembly at its eighth plenary meeting.

It was decided to recommend to the Sixty-ninth World Health Assembly the adoption of three decisions and five resolutions relating to the following agenda items:

- 12. Noncommunicable diseases
 - 12.5 Strengthening synergies between the World Health Assembly and the Conference of the Parties to the WHO Framework Convention on Tobacco Control [WHA69(13)]
 - 12.7 Addressing the challenges of the United Nations Decade of Action for Road Safety 2011–2020: outcome of the second Global High-level Conference on Road Safety – Time for Results [WHA69.7]
 - 12.1 Maternal, infant and young child nutrition
 - United Nations Decade of Action on Nutrition (2016–2025) [WHA69.8]
 - Ending inappropriate promotion of foods for infants and young children [WHA69.9]
- 11. WHO reform
 - 11.3 Framework of engagement with non-State actors [WHA69.10]
- 14. Preparedness, surveillance and response
 - 14.1 Implementation of the International Health Regulations (2005) [WHA69(14)]
- 13. Promoting health through the life course
 - 13.2 Health in the 2030 Agenda for Sustainable Development [WHA69.11]
- 12. Noncommunicable diseases
 - 12.6 Public health dimension of the world drug problem including in the context of the special session of the United Nations General Assembly on the world drug problem, held in April 2016 [WHA69(15)].

COMMITTEE B

First report¹

[A69/69 – 26 May 2016]

Committee B held its first meeting on 25 May 2016 under the chairmanship of Dr Phusit Prakongsai (Thailand).

In accordance with Rule 34 of the Rules of Procedure of the World Health Assembly, the Committee elected Dr Mahlet Kifle (Ethiopia) and Dr Mohsen Asadi-Lari (Islamic Republic of Iran) Vice-Chairmen, and Mr Abdunomon Sidikov (Uzbekistan) Rapporteur.

It was decided to recommend to the Sixty-ninth World Health Assembly the adoption of one decision relating to the following agenda item:

- 19. Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan [WHA69(10)].

¹ Approved by the Health Assembly at its seventh plenary meeting.

Second report¹

[A69/71 – 27 May 2016]

Committee B held its second and third meetings on 26 May 2016 under the chairmanship of Dr Phusit Prakongsai (Thailand) and Dr Mahlet Kifle (Ethiopia).

It was decided to recommend to the Sixty-ninth World Health Assembly the adoption of three decisions and seven resolutions relating to the following agenda items:

- 20. Programme budget and financial matters
 - 20.1 WHO programmatic and financial report for 2014–2015 including audited financial statements for 2015 [WHA69.12]
 - 20.2 Financing of Programme budget 2016–2017 [WHA69(16)]
 - 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 [WHA69.13]
 - 20.5 Scale of assessments for 2017 [WHA69.14]
- 21. Audit and oversight matters
 - 21.1 Report of the External Auditor [WHA69.15]
- 22. Staffing matters
 - 22.3 Amendments to the Staff Regulations and Staff Rules
 - Salaries of staff in ungraded posts and of the Director-General [WHA69.16]
 - Amendments to the Staff Regulations: dispute resolution [WHA69.17]
 - 22.4 Appointment of representatives to the WHO Staff Pension Committee [WHA69(17)]
- 23. Management and legal matters
 - 23.1 Real estate: update of the Geneva buildings renovation strategy [WHA69(18)]
 - 23.2 Process for the election of the Director-General of the World Health Organization [WHA69.18].

Third report¹

[A69/74 – 28 May 2016]

Committee B held its fourth and fifth meetings on 27 May 2016 under the chairmanship of Dr Mahlet Kifle (Ethiopia) and Dr Phusit Prakongsai (Thailand).

It was decided to recommend to the Sixty-ninth World Health Assembly the adoption of two resolutions relating to the following agenda items:

- 16. Health systems
 - 16.1 Health workforce and services
 - Global strategy on human resources for health: workforce 2030 [WHA69.19]
 - 16.4 Addressing the global shortages of medicines, and the safety and accessibility of children's medication
 - Promoting innovation and access to quality, safe, efficacious and affordable medicines for children [WHA69.20]

¹ Approved by the Health Assembly at its eighth plenary meeting.

Fourth report¹

[A69/75 – 28 May 2016]

Committee B held its sixth and seventh meetings on 28 May 2016 under the chairmanship of Dr Phusit Prakongsai (Thailand) and Dr Mohsen Asadi-Lari (Islamic Republic of Iran).

It was decided to recommend to the Sixty-ninth World Health Assembly the adoption of five resolutions relating to the following agenda items:

- 15. Communicable diseases
 - 15.3 Mycetoma
 - Addressing the burden of mycetoma [WHA69.21]
 - 15.1 Draft global health sector strategies
 - Global health sector strategies on HIV, viral hepatitis and sexually transmitted infections, for the period 2016–2021 [WHA69.22]
- 16. Health systems
 - 16.2 Follow-up to the report of the Consultative Expert Working Group on Research and Development: Financing and Coordination – Report of the open-ended meeting of Member States
 - Follow-up of the report of the Consultative Expert Working Group on Research and Development: Financing and Coordination [WHA69.23]
 - 16.1 Health workforce and services
 - Strengthening integrated, people-centred health services [WHA69.24]
 - 16.4 Addressing the global shortage of medicines, and the safety and accessibility of children's medication
 - Addressing the global shortage of medicines and vaccines, and the safety and accessibility of children's medication [WHA69.25].

¹ Approved by the Health Assembly at its eighth 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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