World Health Organization

SEVENTY-THIRD WORLD HEALTH ASSEMBLY | **A73/A/PSR/1**
4 February 2021

COMMITTEE A

PROVISIONAL SUMMARY RECORD OF THE FIRST MEETING

WHO headquarters, Geneva
Monday, 9 November 2020, scheduled at 14:00

Chair: Dr B.-I. LARSEN (Norway)

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COMMITTEE A

FIRST MEETING

Monday, 9 November 2020, at 15:20

Chair: Dr B.-I. LARSEN (Norway)

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

The CHAIR welcomed the participants.

Election of Vice-Chairs and Rapporteur

Decision: Committee A elected Ms Tamara Mawhinney (Canada) and Dr Susie Perera De Silva (Sri Lanka) as Vice-Chairs and Dr Jane Ruth Aceng Ocero (Uganda) as Rapporteur.[1]

PILLAR 2: ONE BILLION MORE PEOPLE BETTER PROTECTED FROM HEALTH EMERGENCIES

2. EPIDEMIOLOGICAL UPDATE ON THE CORONAVIRUS DISEASE PANDEMIC

The EXECUTIVE DIRECTOR (WHO Health Emergencies Programme), providing a technical update on the epidemiological situation, said that the global coronavirus disease (COVID-19) pandemic had continued to accelerate, with approximately 50 million confirmed cases and more than 1.2 million deaths reported to date. The acceleration in the incidence of new cases was most notable in the European Region and the Region of the Americas, which had correspondingly higher mortality rates. The regional variations in transmission rates mostly reflected differences in the intensity of transmission, although some of the variation could be attributed to different testing practices. While the age and gender distribution of confirmed cases had evolved, which was likely to be due to both increased availability of testing and testing of patients with less severe symptoms, males and those over 50 years of age continued to be overrepresented in those figures. More males were also dying from the disease. While the number of deaths was higher for persons aged over 65 years, deaths were also being recorded in the 25–64 years age category, particularly among those with underlying health conditions. Mortality rates had dropped over time for all age groups, reflecting improved clinical care and access to care, alongside better diagnosis and treatment. The recent steep increase in cases could have an impact on access to care, which was a cause for concern, particularly in the European Region where it was reported that some health care systems were struggling. Countries could be divided into four categories of transmission: those with low levels of domestic transmission; those that had suppressed the first wave of infection and had not yet experienced a second wave; those that had suppressed the first wave but were experiencing a second wave; and those that had not yet made it through the first wave.

The Organization's global strategy for COVID-19 response was focused on suppressing transmission and saving lives and livelihoods by mobilizing all sectors and communities, controlling the disease, suppressing community transmission, reducing mortality and developing safe and effective

[1] Decision WHA73(20).

vaccines and treatments. The main challenges encountered with regard to the strategy were sustainable implementation and effective communication that made it acceptable to communities. The Organization had been fully mobilized to support the response and was working with partners to bolster implementation.

Action taken by the Secretariat included monitoring the situation, providing access to training and guidance, and coordinating regularly with Member States, intergovernmental organizations and partners in the United Nations system, including by leading a United Nations Crisis Management Team. Communication was an area of particular focus, with teams trained to manage information and misinformation. Cooperation with social media companies was aimed at understanding public sentiment and responding to it. In terms of support, 170 countries had developed strategic national action plans based on WHO's COVID-19 Strategic Preparedness and Response Plan, 106 regional technical support missions had been deployed to countries, and the WHO Emergency Medical Teams Initiative had deployed 55 international and more than 670 national emergency medical teams. Case studies on response, country readiness assessments and country COVID-19 intra-action reviews were all part of efforts to support Member States, alongside the supply of millions of items of personal protective equipment, diagnostic tests and biomedical equipment and the management of procurement through the United Nations COVID-19 Supply Chain System, which involved multiple partners. A research road map had been developed in February 2020 and more than 500 hospitals were participating in the Solidarity clinical trial for COVID-19 treatments. Prioritized research focused on nine technical pillars, including the animal–human interface.

The focus going forward was on breaking the cycles of transmission and mortality. Global collective action would be critical to reducing and controlling transmission. Individuals and communities should be empowered with the knowledge and resources to sustain and increase risk reduction measures. Public health measures, including to detect, test, provide care and isolate cases, needed to be scaled up, as did measures to trace and quarantine contacts, which would require strengthened and empowered communities and public health infrastructure. Health systems must protect vulnerable groups and provide them with appropriate clinical care. The next phase of the response would also focus on developing diagnostics, therapeutics and vaccines, as well as the long-term preservation and strengthening of health systems. Those activities should be viewed in the context of the Thirteenth General Programme of Work, 2019–2023, and commitments made through WHO's cooperation with other international organizations. By 2021, fully integrated plans should be in place to tackle both COVID-19 and its longer-term health consequences.

The SENIOR ADVISER TO THE DIRECTOR-GENERAL (Organizational Change) provided an update on the activities under the Access to COVID-19 Tools (ACT) Accelerator initiative. The ACT-Accelerator, which had been launched in April 2020, would be crucial to moving out of the acute phase of the COVID-19 pandemic. Its two main objectives were: accelerating the development of COVID-19 tests, treatments and vaccines; and ensuring equitable allocation of and global access to those products. The ACT-Accelerator had support at the highest levels of the United Nations and governments, as well as among academia, industry and civil society, with nine organizations acting as core supporters. Key achievements so far had included the assessment and approval of rapid tests with volume and price guarantees for low- and lower-middle-income countries and the roll-out of the first life-saving therapy, both of which were already making a difference. The economies cooperating through the COVID-19 Vaccine Global Access (COVAX) Facility represented over 90 per cent of the global population. The proportion of vaccine that would be bought through the COVAX Facility would be substantially smaller however, since the aim was to reduce the risk of severe illness from COVID-19 by targeting particular segments of the population. An equitable allocation framework and COVAX allocation mechanism had been established to ensure that those most at risk from COVID-19 and health care providers would have first access to such products.

Continued work through the ACT-Accelerator was expected to enable the roll-out of vaccines – on which there had been some positive interim results – and possibly the use of self-tests and monoclonal antibodies to tackle the disease in 2021. However, urgent political and financial action was needed to prevent a widening gap in access to critical tools for prevention, protection, testing and treatment between low- and high-income settings. The three factors affecting access were: the available financing; the increasing demand for those tools due to escalating rates of COVID-19 in countries in the northern hemisphere; and the capacity of countries with weak health systems to optimize the use of products.

The urgent priority was to change the fundamental dynamic of the pandemic by March 2021. That would be achieved through expanded global testing, improved access to treatments that reduced the risk of death, and readiness to roll out vaccines globally to the populations at highest risk in the first half of 2021. The health systems connector, through close cooperation with the World Bank, UNICEF and WHO, would help countries with weak health systems to put in place rapid assessments and country plans in order to identify and tackle bottlenecks to the delivery of products through key investments.

Despite the significant financing already provided and pledged, the ACT-Accelerator was facing an urgent funding gap of US$ 4.5 billion. That was the figure required for work on diagnostics, therapeutics and vaccines and on the health systems connector to rapidly roll out the products developed at scale. The figure required dwarfed the financing provided annually as official development assistance for health; additional financing streams were therefore needed. An urgent advocacy campaign was ongoing and concessional loans and private sector financing were also being considered as sources of funding. Countries were also encouraged to invest in the ACT-Accelerator. The global income gained as a result of bringing COVID-19 under control would offer a significant return on investment in terms of economic and societal recovery, alongside the crucial act of saving countless lives.

3. REVIEW OF AND UPDATE ON MATTERS CONSIDERED BY THE EXECUTIVE BOARD: Item 13 of the agenda

Independent Oversight and Advisory Committee for the WHO Health Emergencies Programme: Item 13.1 of the agenda (document A73/10)

WHO's work in health emergencies: Item 13.2 of the agenda (documents A73/11, A73/INF./4 and EB146/2020/REC/1, resolution EB146.R10)

INTERNATIONAL HEALTH REGULATIONS (2005): Item 14 of the agenda (document A73/14)

The CHAIR invited the Committee to consider the draft resolution contained in resolution EB146.R10.

The CHAIR OF THE INDEPENDENT OVERSIGHT AND ADVISORY COMMITTEE for the WHO Health Emergencies Programme, introducing the Committee's report contained in document A73/10, provided an overview of the main findings and recommendations contained in the report. She welcomed the Secretariat's dedication and tireless efforts to fully realize the ambitions of the WHO Health Emergencies Programme and acknowledged the progress and achievements of the past four years.

The work of WHO in outbreaks and emergencies needed to be reflected in every aspect of the Organization as a core part of its mandate. The Emergency Response Framework should be updated with explicit roles and responsibilities for each player and updated processes for all-hazards emergency risk management. The flexibility of the WHO Health Emergencies Programme should be further improved by assigning it an appropriate level of autonomy and authority. In addition, a formal dialogue

should be organized to establish an appropriate mechanism for engagement with Member States, which would help to ensure alignment between Member States' expectations and WHO's authority and capacities to address emergencies.

Although country and regional offices now played a more pivotal role in coordinating regional platforms and providing insights into geopolitical issues that had an impact on WHO's emergency response, the COVID-19 pandemic had demonstrated the need to revise the country business model.

The administrative system and business processes for human resources and procurement continued to represent major constraints for WHO's emergency operations. The centralization of enabling functions should ensure the agility, flexibility and effectiveness of the WHO Health Emergencies Programme. Periodic reports should be submitted to the Committee on key performance indicators for all centralized functions in order to track their impact on WHO's emergency operations, and dedicated teams to support emergencies should be established within the centralized functional divisions.

The COVID-19 pandemic had called into question the adequacy of the Organization's financing. Given the scale and frequency of health crises, the budget of the WHO Health Emergencies Programme should be reviewed accordingly, as the Organization faced chronic financial challenges, a lack of predictable and flexible funding, and competing priorities, with a heavy dependence on a limited number of donors. In view of the significant discrepancy between Member States' contributions and their expectations of the WHO Health Emergencies Programme, they should be invited to consider an increase in assessed contributions. It was also necessary to increase the proportion of WHO core flexible funding allocated to the WHO Health Emergencies Programme. Management of the Contingency Fund for Emergencies, as well as its relationship to other humanitarian funding streams for health emergencies, must be redesigned in response to concerns raised by donors.

As WHO's role in major emergencies grew, the risks inherent in operating in fragile States had significantly increased, as evidenced by the allegations of sexual exploitation and abuse linked to the Ebola virus disease response in the Democratic Republic of the Congo. The Independent Oversight and Advisory Committee commended the Director-General's prompt action in setting up an independent commission on sexual misconduct, and underscored the importance of identifying systemic issues and implementing institutional measures in all emergency settings.

The COVID-19 pandemic had highlighted the importance of WHO's normative and policy-setting functions. Although there was already close collaboration between the WHO Health Emergencies Programme and the Science Division, WHO should strengthen the Programme's capacities to provide scientific advice and technical guidance. It was important to enhance partnerships, including with WHO collaborating centres and technical advisory bodies, in order to maintain a balance between technical rigour and rapid policy guidance. In addition, a small, dedicated team of social scientists and gender equality experts should be established to take into account the socioeconomic and gender-related implications of public health emergencies. WHO should also continue its active involvement in global efforts to promote equitable access to COVID-19 vaccines and treatments.

Steady progress had been made in strengthening partnerships with Member States and other stakeholders, and in engaging with civil society and the private sector. Although WHO's leadership role in global health emergencies had been strengthened through the COVID-19 pandemic, an improvement in supply chain management and partner coordination was required. Progress had also been made in fostering operational partnerships, including in WHO's health cluster coordination and leadership, although there was a heavy reliance on the individual abilities of health cluster coordinators. Systematic measures and institutional support were needed to ensure that WHO provided both strong coordination and technical and operational support to partners on the ground.

She welcomed the establishment of the Independent Panel for Pandemic Preparedness and Response and the Review Committee on the Functioning of the International Health Regulations (2005) during the COVID-19 Response. The Secretariat should improve existing tools and mechanisms to support Member States in building the core capacities required by the International Health Regulations

(2005) and enhance the system for declaring a public health emergency of international concern, which had received an inconsistent response at the global level during the COVID-19 pandemic.

Although past and present members of WHO's senior leadership team deserved credit for the impressive progress made over the past four years, the COVID-19 pandemic had tested the Organization as never before and placed it under global public scrutiny. The WHO Health Emergencies Programme had been shaped by the Ebola virus disease outbreak in West Africa, enabling it to respond to events of similar severity and scale, but not a global pandemic; further reform might therefore be needed to enable the Organization to effectively perform its role as guardian of global public health.

The CHAIR OF THE REVIEW COMMITTEE ON THE FUNCTIONING OF THE INTERNATIONAL HEALTH REGULATIONS (2005) DURING THE COVID-19 RESPONSE recalled that the Review Committee had been convened by the Director-General in accordance with resolution WHA73.1 (2020) and Article 50 of the International Health Regulations (2005) to make technical recommendations regarding the functioning and possible amendment of the Regulations. To date, the Review Committee had held nine closed meetings and three open meetings, which had been attended by over 100 representatives from Member States, international agencies and non-State actors, and an initial update and progress report had been submitted to the Executive Board at its fifth special session in October 2020.

The Review Committee had three subgroups focused on preparedness, alert and response. The key questions being addressed on preparedness included whether the current tools for assessing and monitoring the core capacities required by the International Health Regulations (2005) covered all the necessary capacities, including at the subnational level; and how the tools to assess and monitor preparedness, including universal peer reviews, could better help countries implement a more effective response. The alert subgroup was considering how information had been shared under the Regulations during the early days of the outbreak; whether WHO needed a stronger mandate to react if States Parties did not provide information; and whether the determination of a public health emergency of international concern and its consequences were clearly understood. Issues related to response included the implementation of obligations regarding additional health measures in relation to international traffic; and how to improve current mechanisms for collaboration and cooperation during a global outbreak response.

Preliminary findings had indicated that the assessment and monitoring of preparedness, as well as core capacities, needed further examination based on the observed performance of Member States in their COVID-19 response, potentially through a peer review mechanism. It had also been found that both official information and information from media, social media and rumours, were useful for surveillance; the provisions for notification and verification of information under the International Health Regulations (2005) therefore required further examination to establish why some governments had been reluctant to share early reports, and whether incentives could improve compliance. Incentives would also be considered to increase compliance with the obligations related to travel, in view of the widespread implementation of national travel restrictions during the COVID-19 pandemic. The rapid risk assessments provided by WHO for events involving the risk of international spread had proven to be of utmost importance, while the mechanism for declaring a public health emergency of international concern required further examination, as did the possibility of establishing an intermediate level of alert. It was clear that an effective response to global public health risks required strong support for outbreak alert and response mechanisms, appropriate national legislation, strong public health and health care systems, and recognition of the authority of National IHR Focal Points.

The Review Committee had also started to examine more general issues, such as whether the International Health Regulations (2005) were fit for purpose and whether there were challenges in their design or implementation that had raised concerns during the COVID-19 response. Financing had to be considered at the national and international levels, in addition to the functions and effectiveness of governance bodies and mechanisms under the Regulations. The Review Committee was also performing a systematic review by analysing each article of the Regulations to identify whether any amendments

were required, and examining the progress made in implementing the recommendations of previous review committees. A range of experts, WHO staff, National IHR Focal Points and chairs of former review committees had been consulted, and regular discussions were also being held with the Chair of the Independent Oversight and Advisory Committee and the Co-Chairs of the Independent Panel for Pandemic Preparedness and Response. Recalling that the Review Committee was a technical expert group that could only make recommendations, he stressed that no amendments could be made to the Regulations without the approval of the Health Assembly, and Member States' input would be given close attention. The Regulations were a shared instrument that everyone should contribute to improving in order to better prepare and protect humanity against public health risks.

The representative of GERMANY, speaking on behalf of the European Union and its Member States,[1] said that the candidate countries North Macedonia, Montenegro and Albania, as well as Ukraine, the Republic of Moldova and Armenia aligned themselves with his statement. Observing that the COVID-19 pandemic had further underscored the need for global multilateral cooperation and resilient health systems, he commended WHO for its increasingly efficient work in emergencies and for advancing the ground-breaking collaboration under the ACT-Accelerator. He welcomed the work of the evaluation and review mechanisms and the recent progress regarding the WHO-convened study on the origins of the virus, and called for full transparency and cooperation during all its phases.

There was a gap between Member States' expectations of WHO and the Organization's capacities to fulfil them; global health was indeed a shared responsibility, and Member States must play their part, including by ensuring predictable, flexible and sustainable financing. The European Union stood ready to take a leading role in strengthening WHO, and had launched an inclusive process open to all Member States to discuss ideas for reform. He reaffirmed the European Union's commitment to the International Health Regulations (2005) as a unique binding legal instrument, while recognizing that they needed strengthening, notably with regard to travel and trade restrictions; independent epidemiological on-site assessments; reporting by States Parties; monitoring and evaluation; and through revision of the system for declaring a public health emergency of international concern. He supported the draft resolution on strengthening preparedness for health emergencies recommended in resolution EB146.R10, as it would give WHO the mandate to further support countries to fully implement the Regulations.

Speaking in his national capacity, he said that the COVID-19 pandemic should be understood as a game changer; no one had been adequately prepared for the largest global health crisis in decades. WHO was only as capable as its Member States made it, and there was a major discrepancy between their desire for a well-functioning and effective Organization and their will to finance it. His Government was prepared to explore all possible options to strengthen WHO. However, a strengthened WHO would only be possible if all Member States took on more financial responsibility.

The representative of SOUTH AFRICA, speaking on behalf of the Member States of the African Region, commended the way in which WHO had risen to the challenge of the COVID-19 pandemic, which was a reminder of the need for strong, resilient and integrated health systems. Resolution WHA73.1 provided guidance on responding to the pandemic, and the Member States of the Region particularly welcomed the appointment of the Independent Panel for Pandemic Preparedness and Response. However, despite encouraging multilateral cooperation on preparedness and response, there remained an urgent need for additional funding to drive innovation and research and development and to ensure that all countries had equitable, affordable and timely access to tools to fight COVID-19.

[1] At its *de minimis* meeting in May 2020, the Seventy-third World Health Assembly invited the European Union to attend and participate without vote in the deliberations of the meetings of its sub-committees, drafting groups or other subdivisions addressing matters falling within European Union competence.

Strong emphasis must be placed on health systems. The report on public health preparedness and response indicated encouraging progress regarding operational capacity, the deployment of experts and multidisciplinary teams, and the provision of guidance documents. However, it also indicated that the African Region was one of the regions most affected by funding shortfalls, limited human resources, attacks on health care workers and facilities, and disruption to health services. Some of those issues had been addressed by the Regional Committee, and he thanked the Regional Director for the work of the Regional Office in that area.

He looked forward to the work of the Review Committee on the Functioning of the International Health Regulations (2005) during the COVID-19 Response, including on developing a more sensitive alert system and improving joint external evaluations. Calling on the Secretariat to swiftly act on the recommendations made by the Independent Oversight and Advisory Committee, he urged Member States to strengthen the implementation of the International Health Regulations (2005) in their own countries. WHO had indeed established itself as a global leader in emergencies during the COVID-19 pandemic and should be congratulated on its foresight in establishing the WHO Health Emergencies Programme, which had proven sufficiently agile to take on new challenges. It was now necessary to increase the resources for work on emergencies to ensure adequate, flexible funding and to allow low- and middle-income countries to improve their response. He supported the draft resolution contained in resolution EB146.R10.

The representative of the ISLAMIC REPUBLIC OF IRAN, speaking on behalf of the Member States of the Eastern Mediterranean Region, said that his Region was all too familiar with emergencies, and that the COVID-19 pandemic had added another layer of complexity to numerous existing challenges. Although transmission of COVID-19 had been slow initially, the number of cases had increased following the relaxation of social measures and travel restrictions, and due to cooler weather and growing COVID-19 fatigue. Thanks to a comprehensive response and strong regional coordination, good progress had been made, despite the diverse nature of Member States in the Region. However, many challenges remained, and accelerated efforts were needed to improve the scale, quality and monitoring of public health interventions. Health care workers must be better protected, and compliance with personal protective measures, such as hand hygiene and mask-wearing, needed to be enhanced. The most restrictive social measures, such as lockdowns, should be targeted, short-term and evidence-based; he therefore asked the Secretariat to provide timely evidence regarding such measures to all Member States.

It was clear that responsible, transparent leadership played a vital role, as did active community engagement and multisectoral collaboration. There was a particular need for investment in the core capacities required by the International Health Regulations (2005), and all governments needed to work to increase investments in health and human capital. Meanwhile, other major humanitarian crises should not be forgotten; strengthening capacities for comprehensive, all-hazards emergency risk management would enable the Member States of his Region to more effectively prepare for and respond to the frequent natural disasters that occurred in the Region. Stressing that the WHO Health Emergencies Programme should continue to play a central role in emergency prevention, preparedness, detection and response, he expressed support for the recommendations made by the Independent Oversight and Advisory Committee. The first progress report of the Independent Panel for Pandemic Preparedness and Response was also encouraging and he looked forward to its further work and recommendations.

The representative of AZERBAIJAN, speaking on behalf of the Non-Aligned Movement, outlined a range of mechanisms introduced by the Movement in response to the COVID-19 pandemic and reiterated its support for WHO, which was playing a critical role in supporting the international community. It was important to remember that essential goods, such as food and medicines, should not be used as tools for political coercion; COVID-19 vaccines should also be classified as global public goods. Enhanced efforts were needed to ensure unhindered, equitable and affordable access to and provision of all COVID-19-related diagnostic tools, therapeutics and vaccines. There was also an urgent

need to accelerate progress towards achievement of the health-related Sustainable Development Goals, improve the resilience of health systems, enhance health emergency preparedness and response, and support progressive realization of universal health coverage. He urged the Secretariat to continue to provide unhindered support to governments, while paying special attention to the needs of the most vulnerable populations, in order to protect human dignity and ensure that no one was left behind. To ensure the effectiveness of national responses to the COVID-19 pandemic, Member States should refrain from implementing unilateral coercive measures.

(For continuation of the discussion, see the summary records of the second meeting.)

The meeting rose at 17:05.

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