WHO Watch Report

Highlights from the fifth day of the 66th World Health Assembly

24 May 2013

Committee A

Item 15.1: Implementation of International Health Regulations (2005)

Background

Document A66/16 (as amended in A66/16 Add.1) provides an update on progress made in taking forward the recommendations of the Review Committee on the Functioning of the International Health Regulations (2005) (see A64/10) in relation to Pandemic (H1N1) 2009, as requested in resolution WHA64.1. This report also takes into account information provided by States Parties on the implementation of the Regulations and describes the Secretariat's related support activities, in line with the annual reporting mechanism established under resolution WHA61.2(p3). In addition, it contains sections on the proposed monitoring of national core capacities and the development of criteria for future extensions (of time for fulfilment of the obligations under the IHRs), as requested in resolution WHA65.23 (p39).

The International Health Regulations (IHRs) date back to the Sanitary Conferences of the 19th century dealing with disease notification, vaccination for travel, quarantine etc. They were under review in the 1990s but this review was greatly accelerated by the SARS epidemic (severe acute respiratory syndrome) in 2003. The new version of the IHRs from 2005 included explicit obligations on member states. However, some member states had not put in place all of the resources and systems required for the full implementation of the IHRs by the deadline of end 2012 and required extensions of time to fulfil their obligations. Some of these states may apply for a further extension beyond 2014. This paper sets out the current status with respect to member state implementation of the 13 elements being monitored. It also sets forth possible criteria for further extensions of time for implementation in 2014.

Following the H1N1 pandemic in 2009 there was some controversy over the application of the IHRs and the Review Committee was set up to report to the Assembly about the application of the IHRs in this context. This paper reports on progress in the implementation of the 15 recommendations of this committee also.

Summary of debate (23 and 24 May 2013)

The discussion of this item commenced with a briefing from Saudi Arabia on the novel coronavirus outbreak, focusing in particular on the outbreak in April-May 2013 in Al Hasa region, eastern province of Saudi Arabia. This outbreak was identified in a private facility where there were a high number of cases of pneumonia resulting in increased deaths.

It was also reported that the development of diagnostics has been hampered by the fact that the virus was patented by scientists.

See WHO>GAR>Coronavirus for more details.

(Discussion recommenced on 24 May)

Some delegates spoke about their own institutional arrangements for surveillance, laboratory diagnosis etc and in some cases acknowledged that they were behind in complying with the requirements of the IHRs. Many mentioned the need for technical and financial support. Others spoke about the resource mobilisation to support LICs to comply with the IHR requirements. There was general support for the proposed criteria for giving countries extensions with respect to complying. Other spoke about international communicable disease control more generally.

In concluding the debate the ADG emphasised the importance of close attention to H7N9 and the novel coronavirus. It was noted that a number of countries were requiring extension but that the sense of urgency to implement build core capacities is strong. The definition of core capacities will go back to regional committees following this Assembly. There have already been a number of meetings, two in Africa to bring MS from the region and donors and technical support from the WHO. WHO can provide coordination but many of the lagging MSs really require funding. We are working very hard to keep this process going.

The Assembly noted the report.

PHM Comment

The IHRs are an important institution for global public health protection. They impose binding obligations on states in order to ensure the protection of people in different countries. It is proper that states should be obligated to implement these regulations. The Secretariat is doing a good job in strengthening the systems of surveillance and monitoring upon which these regulations depend.

WHO appears to have responded promptly and sensibly to the outbreaks of H7N9 and the novel coronavirus.

It is regrettable that the investigation of the novel coronavirus outbreak has been obstructed by the patenting of the virus.

The IHRs reflect WHO at its best. However, there is a stark contrast between the use of a binding instrument to contain the risks of pandemic communicable disease and the opposition to any such obligations in relation to the international marketing of breast milk substitutes and cheap junk food. In fact, investment protection provisions in new trade agreements are deliberately designed to protect transnational corporations from any such regulatory obligations.

Item 13.3 (continued) – Draft comprehensive mental health action plan 2012-2020

The Committee revisited the Draft Comprehensive Mental Health Action Plan today following deliberation from Wednesday. In early discussions as noted in the Day 3 Report, Member States offered amendments which were circulated in document A66/A/Conf./4.

The amendments were adopted with the following to be noted:

- Bangladesh withdrew amendment to Paragraph 5 of the resolution as Switzerland pointed out that the change is didactic and takes away from the elegance of the paragraph.
- Trinidad and Tobago consulted with other Member States and withdrew their amendment to Target 3.1.

During the session Trinidad and Tobago suggested a small amendment to Objective 1, bullet point 1 to insert "…through [*programs to improve mental health literacy and*]…" However, they withdrew the amendment as Switzerland pointed out that "health literacy" is hard to understand in French.

After agreeing on the amendments, the Committee adopted the Resolution to implement the Comprehensive Mental Health Action Plan!

This is a good step forward for mental health becoming seen as an important part of global health and "health for all". Civil society should monitor progress of implementation of the action plan at the national level and ensure that stakeholders, especially people with mental illness and their families, are included in any policy-making or other process.

Item 13.5 (continued) – Disability

Document: A66/A/Conf./5

Further to discussion on Wednesday, Disability was revisited. A conference document containing amendments had been circulated. However, Ecuador had consulted with Member States who had participated in previous conversation and offered a new, agreed upon proposal. After reading through new amendments, the Committee adopted the resolution!

Subsequent to this, WHO should begin developing a plan or guide to aid countries in streamlining the needs of people with disabilities in their health planning.

Item 15.2: Pandemic influenza preparedness: sharing of influenza viruses and access to vaccines and other benefits

Documents: A66/17; A66/17 Add.1

Background

In resolution WHA64.5 the World Health Assembly adopted the Pandemic Influenza Preparedness Framework ("PIP Framework") on 24 May 2011. The DG is required to

inform the WHA, through the EB, on the status of, and progress on areas covered by the framework, including:

(i) Laboratory and surveillance capacity;

(ii) Global influenza vaccine production capacity;

(iii) Status of agreements entered into with industry;

(iv) Financial report on the use of the partnership contribution;

(v) The experience arising from the use of the definition of PIP biological materials

Under this agenda item the report presents summary information on the status and progress of these topics and the Assembly was asked to note the report.

Member states generally expressed satisfaction with progress.

Some key issues and concerns raised by member states and subsequently clarified by the Secretariat included:

- Current H7N9 outbreak is a test for the PIP framework
- More work is required to promote technology transfer to countries without capacity, at present, for vaccine manufacture
- Accelerated progress is needed on Standard Material Transfer Agreement 2 (SMTA2). May be noted here that the WHO has initiated discussions with several large influenza vaccine manufacturers to commence Material transfer Agreements. Agreements have been completed with GSK and the University of Florida. Five other are under way with various companies and entities.
- Process needs to be more transparent, especially to ensure that benefits are equitably shared by countries (Brazil's intervention)
- Synergy required between PIP and other frameworks such as on IHRs (USA's intervention).
- Need for revision of guidance on pandemic preparedness in view of experience of 2009 H1N1 pandemic outbreak (Japan's intervention). WHO has been consulting with experts to revise guidelines.

Greater transparency regarding benefit sharing and agreements being made with commercial entities.

15.3 Poliomyelitis: Intensification of the Global Eradication Initiative

The Assembly was invited to note the document A66/18 regarding the process of the global polio eradication initiative. As such, delegates from endemic shared notes on their progress and various challenges, while those from donor countries spoke about the funds that they had pledged to the new 2014 budget earlier during the April 2013 Global Vaccine Summit in Abu Dhabi. Speakers especially provided sincere condolences for the health workers who had died while delivering vaccination services due to such regional instabilities.

Several speakers during the Assembly noted that the persistent funding gap for the 2014 polio eradication campaign budget threatens the progress made in previous years. Countries, as well as the Secretariat, called for the improved political commitment that is ultimately required to ensure that polio is officially eradicated within the next 6 years.

While universal vaccination is necessary to ensure the eradication of this disease, at no point did any of the speakers touch on the importance of also tackling the wider social determinants of health that ultimately serve asthe root causes of polio. Moreover, there was no discussion of the role of health systems in ensuring the sustainability of immunization campaigns in endemic and low income countries.

Committee B

Item 17.3 – Universal health coverage (UHC)

Documents: A66/24, A66/A/Conf./2, A66/A/Conf./2 Add.1

Background

In this discussion, the 66th WHA was invited to note the secretariat (document A66/26). This is an updated version of the report on UHC which was reviewed by the 132nd EB session. The original version was edited to incorporate 1) the recommendations of member states during the EB discussions, and 2) the results of the ministerial meeting on UHC held in February 2013. The report outlines the major components of UHC, and charts relevant progress, challenges, and continued and future efforts of the WHO to provide technical support to Member States for financing for UHC.

Summary of the discussion

Health workforce: Thailand stated that health workforce is neglected and requested a formation of drafting committee. Norway, Indonesia, Malaysia, China, Maldives, Vietnam and Philippines echoed this concern and supported the request.

Equity: The issue of equity was raised by the majority of member states. It varies from equal access to health care services (as expressed by USA, Mexico, Philippines…) to addressing health inequalities through actions on health determinants (as expressed by South Africa on behalf of African countries and other states). Brazil considered that the UHC is a fundamental tool for equity and rights based development.

Health system strengthening and addressing the social determinants of health (SDH): Several member states mentioned the SDH. The EU stated that the UHC needs capable health system and this system should adopted broader perspective of public health to address the SDH needs health systems with broader public health perspective. South Africa noted that achieving the universality can be achieved through the PHC approach and measures to ensure the accountability and ownership. The ability of health system to protect the needs of the marginalized groups was also emphasized by the EU. Senegal suggested specific change through mentioning the need to address the SDH in paragraph 24. Senegal

also requested an addition in paragraph 15 emphasizing that health map should be kept updated and account for the potential risk factors.

Switzerland indicated that the UHC can be achieved through efficient health system that adopts multi-sectoral approach and takes into consideration the social, economic and environmental determinants and referred to the Rio Political Declaration on SDH. Philippines stressed that the coverage should be expanded to include the marginalized groups; e.g. indigenous population, orphans, etc. Vietnam emphasized that medicines, workforce and information system are key issues to address while working towards UHC. USA stated that the achievement of UHC belongs to the national governments in different ways. Lebanon emphasized the importance of engaging the private sector. El Salvador emphasized the importance of international solidarity to achieve the UHC.

The post-2015 developmental agenda: Several countries emphasized the importance of including the UHC in the post-2015 developmental agenda with clear targets and strategies to achieve them (USA, Mexico, EU, Colombia, Canada, Singapore, Maldives, Lebanon, Ethiopia and Korea and Vietnam). Brazil insisted that universal public equitable quality health care system should be on the top of the post-2015 development agenda. It also emphasized the need to further communication among the emerging economy countries (Brazil, Russia, India, China and South Africa).

NCDs: The USA called for adding the NCDs to the agenda of the UHC focusing on the prevention aspects.

Quality: Several member states emphasized the importance of universal access to quality health services (Mexico, South Africa on behalf of African region, Colombia)

Minimum package: The EU and Vietnam criticized the minimum package approach indicating that it is not enough.

Finance: South Africa on behalf of African countries and Malaysia indicated that the plan of action focused on the finance rather than other items including the acceptability, availability and quality especially at the primary level. Same countries and Philippines emphasized that financing the UHC should account for the right to quality health services and medicines at affordable cost without financial risk. Korea and Singapore emphasized the importance of identifying sustainable mechanisms of financing the UHC. China indicated that the WHO should convince the NGOs to move their investments to the UHC. Maldives emphasized the public finding and the use of different mechanisms to reduce the health expenditures partially through expanding the use of generic drugs and bulk purchase. Jordan echoed the importance of finding sustainable financial mechanisms. Vietnam suggested that health budget should be 10% of the national GDP. It emphasized the importance of investments in the health facilities on district and community levels to reach the marginalized groups and ethnic minorities.

Partnership: The EU indicated that the developmental partners should align their efforts and suggested the IHP as an umbrella or other mechanisms. Korea welcomed the cooperation with the World Bank and supported forms of multilateral cooperation to achieve the UHC.

Medicines: Colombia suggested the importance of studding the factors behind the shortage in essential drugs to develop effective management strategies. Maldives stated that

medicines related expenditure is the largest item of out-of-pocket. It emphasized the importance of expanding the use of generic drugs and bulk purchase to reduce the cost.

Role of WHO: The role of WHO was emphasized in terms of: 1) coordinating the efforts towards the achievement of UHC (Switzerland), 2) technical and financial support (African countries), 3) enhancing the initiatives of global health diplomacy (Japan, Indonesia), 4) capacity building especially for enhancing the different stakeholders in financing the UHC (Malaysia and Lebanon). Malaysia also indicated that the lack of resources limited the WHO support earlier.

Unfinished business, monitoring, evaluation and way forward: Japan suggested the importance of work at bilateral and regional levels using the concepts of international health diplomacy to cooperate towards achieving UHC and address the related challenges. Malaysia suggested that the plan of action should tackle other aspects rather than finance including tools for monitoring, legal and regulatory framework, patient safety and quality of care. Korea suggested that plan of action should include clear strategies linked to health outcome. China requested the WHO to clearly define the UHC and what does it entail regarding health services, legislation, etc. It also emphasized the need to time table and road map. Singapore emphasized that the road to achieve the UHC is complex and there is no single plan can be implemented globally. Maldives suggested regional strategies based on consultation and benefit from the existing evidence.

The Statement presented by PHM and MMI can be accessed at: Statement by PHM and MMI on Universal Health Coverage

Item 17.2 – Follow-up of the report of the Consultative Expert Working Group on Research and Development: Financing and Coordination

Document: A66/23

Background:

The resolution before the Assembly is a follow-up to the Report of the WHO's Consultative Expert Working Group (CEWG) on the on the implementation of CEWG recommendations.

The CEWG Report made a set of important recommendation with regard to coordination, monitoring and financing of R&D to meet the unmet R&D health needs of developing countries. One of the key recommendations of the Report is the establishment of a legally binding instrument for the coordination and sustainable financing R&D to address those unmet health R&D needs. The Report also recommended a set of principles and objectives of the instrument, which includes open innovation and delinking of the cost of R&D from the price of product.

The CEWG was established in 2010 to follow up on the Report of the Expert Working Group on R&D Financing and Coordination, to implement WHO's Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property. In particular, it was appointed to implement Element 7.1(a) of the Global Plan:

" … *establish a results-oriented and time-limited expert working group under the auspices of WHO and linking up with other relevant groups to examine current financing and*

coordination of research and development, as well as proposals for new and innovative sources of financing to stimulate research and development related to Type II and Type III diseases and the specific research and development needs of developing countries in relation to Type I diseases;…"

The 65th WHA in 2012 adopted resolution WHA 65.22 to carry out the follow up on the CEWG Report. Among other things it mandated an open-ended meeting, which was held on 26-28 November 2012. The 66th WHA is required to consider the outcome document of the open-ended meeting, which includes a report and the draft resolution as an appendix.

The legitimacy of the outcome document has been a source of some controversy. Only 81 out of 194 WHO Member States attended the open-ended meeting. Further, according to a developing country negotiator at the time of the finalization of the report and the draft resolution, there were only around 20 Member States inside the negotiating room.

One of the most contentious paragraphs in the open-ended meeting report stated: "*the open ended meeting of Member States strongly recommends that the Executive Board considers this report and its attached draft resolution with a view to recommending the adoption of the resolution by the World Health Assembly without reopening it*". One delegates wondered how one tenth of WHO Member States could make such strong recommendations to the other 173 odd Members States to surrender their constitutional right.

Many Member States challenged this recommendation during the January Executive Board meeting, and the report and the draft resolution were not approved. The Assembly, thus, has the opportunity to discuss, and if felt necessary, amend the report and resolution of the report of the open ended working group.

The resolution proposes some concrete actions, including the establishment of a global health R&D observatory; and the implementation of a few health R&D demonstration projects. However concerns were expressed by many that the draft resolution doesn't reflect several CEWG recommendations. For example the resolution does not propose a binding agreement on a global R&D treaty. In fact the resolution postpones discussion of an R&D Convention at the WHO (Par. 4(7) to 2016.

The following is a summary of important interventions by member states:

China: Hope that the observatory will create a network for promoting R&D, hope that these projects will provide importance for long term sustainability of R&D work. Express the opinion that the resolution does not address many important issues adequately but is willing to support it if this is the best consensus possible.

India: CEWG recommended a binding commitment, but consensus fell short. It is critically important to resolve these contentious issues. We need a continued discussion to find solutions.
[This was followed by the US, which made an unexpected recommendation regarding the convening of an advisory meeting (unexpected because it had been anticipated that the US would not want to change the draft resolution – *editorial comment*)]

USA: Believe that the resolution represents our best opportunity to increase R&D for diseases in that are primarily affecting developing countries. Market forces alone won't solve these issues. Would like to propose an additional decision point on this item: MS direct WHO Sec to convene an advisory meeting including govt reps and tech reps and private sector at the earliest possible date in order to take action for global R&D financing in accordance with the terms of the resolution including bio-medical research community and R&D funds managers. This group will define methodologies for coordinating research in ways that emphasize de-linkage from product to price and seek voluntary financing to demonstration projects. We can't put resources into a resolution that is not clearly defined. We need to define projects. There is flexibility in the next MS meeting date in the resolution. If this advisory committee can demonstrate progress on these projects, the US would be willing to meet at an earlier rather than later. Suggest that we extend the item to allow additional consideration of the decision point.

Chad (on behalf of 46 African countries): At the current stage, funding for R&D has not been optimal for African countries due to market mechanisms. Need a fund for R&D, which can comprised of voluntarily contributions from Member States and donors

Ireland (on behalf of EU): Support reports and recommendations of the plan. Need to define how finances can be raised. USA proposal could be considered.

Japan: Current R&D is insufficient for diseases like TB, malaria and NTDs. Japan, BMGF, and Japan's companies established the global health innovation technology fund.

Bolivia (on behalf of UNASUR): Funds have been insufficient for R&D. Support global observatory as a global opportunity. The use of open platforms and collaboration in research to create global public goods should be part of the guiding principles. We should discuss this sooner than at the 69th Assembly (in 2016 as mandated in the resolution). We are aware of the proposal made by the US, we are willing to work with them to find a common point

Indonesia: Support India; current activities are not sufficient for addressing R&D globally. Would like to highlight the need for capacity building in technology transfer in LMICs. Reiterate support for full funding at the global level for (R&D on unmet needs).

South Africa: View this as an opportunity to address market failure through co-ordination and pooling of resources. Noted comments made by USA and Bolivia and support the principles.
Maldives: Need for all health partners to share health R&D contributions for the global observatory. Want more concrete financing mechanism that the voluntary mechanism.

Argentina: Draft resolution represents a consensus, but the consensus is only on partial areas and insufficient to address the problem. Takes note of US suggestion and we are open to dialogue. The draft resolution should be approved without para 4.7 (asking that there be further discussion regarding proposal to postpone negotiations on R&D treaty to 2016 – *editorial comment*)

France: Yet to have an appropriate framework, especially for developing countries. Proposal made by the US is appropriate but the advisory meeting should include NGOs and CSOs.

Colombia: Committed to seeking solutions to outstanding matters outlined by CEWG.

Korea: Need a global convention on global healthcare R&D but we want a study in advance.

Switzerland: Suggests linking the results of demonstration projects with future discussions on a global R&D mechanism

Canada: Agrees that inadequate monitoring of R&D is a barrier to identify gaps. Supports review of existing mechanisms that help with coordination on R&D. Support the US decision point

Tanzania: Acknowledge the step-wise approach. Willing to engage in dialogue with US decision point. Endorse the resolution without amendment.

Zimbabwe: The recommendations should include more and the meeting to discuss outstanding issues in CEWG report should be in 2014 and not 2016.

Followed by statements by NGOS, including MMI/PHM, HAI/KEI, MSF. All the statements call for more urgency in dealing with outstanding issues of the CEWG and for better definition of the work of the observatory and of the demonstration projects.

Chair: **I see significant support for the resolution. Suggest that we spend time on the additional draft (suggested by the US) then when we're clear, we** come back to the formal approval of the resolution, and the formal approval of the draft decision.

Text of US proposal:

Directs the WHO Secretariat to convene an advisory meeting including government representatives and technical experts from external stakeholders and the private sector at the discretion of the Secretariat at the earliest date, in order to take forward action in relation to monitoring, coordination and financing for health R&D, in accordance with the terms of Resolution A66/XX. Such a meeting should particularly including members of the biomedical research community at a technical level and those currently involved in managing funds for research and development, with a mandate to:

1) assist in the identification of translational research projects and the methodologies for coordinating research for the demonstration projects, in ways that emphasize the de-linkage of cost of R&D from product price; and

2) Identify ways to promote advocacy for identified R&D needs, and seek voluntary financing for the demonstration project.

USA: We had some discussion during lunch. Colleagues from Ecuador and Argentine came to us proposing some changes. The points raised by France are also very important: inclusion of Civil society; supervision of the meeting by the governing bodies of WHO.

Thailand: We welcome the proposal and want to suggest that the 'discretion of Secretariat' be deleted; and 'priority' added in front of R&D in last sentence

Bolivia (for UNASUR): We have problems with the proposed language; we are willing to work on alternatives. After the word "voluntary" we would like to add the words "sustaniable financing". US has suggested the first 2 months of 2014 (to convene the advisory meeting) and we agree with that

Ireland: Wants to delete the word "translational" and instead add 'consider all appropriate projects'

South Africa: Collapse the membership sections to one sentence. We can't limit demonstration projects to just translational research.

Argentina: Where there is reference towards other interested groups, we want to add a reference to conflicts of interest. Also agree to deletion of 'translational'.

Chair: An informal group will be meeting to clean the text.

The Item shall commence on Monday, 27th May, and shall consider the text being worked out by the informal group, which involves among others the US, and UNASUR countries

Item 17.1 – Substandard/spurious/falsely-labelled/falsified/counterfeit medical products

Document: A66/22

Background:

The Sixty-fifth World Health Assembly adopted resolution establishing a Member State mechanism on substandard/spurious/falsely-labelled/falsified/counterfeit medical products. The first meeting of the mechanism took place in Buenos Aires, in November 2012. The meeting decided that regional groups would agree among themselves on a Chairperson and submit to the Secretariat the names of two Vice-Chairpersons per region; those officers would form the Steering Committee. Member States have not yet agreed on a Chairperson for the mechanism and discussions are ongoing,

At the informal meeting of the Steering Committee it was decided that an Open Ended Working Group be convened as soon as possible after the Sixty-sixth World Health Assembly. The Secretariat was requested to identify possible dates for the second meeting of the Member State mechanism. It is anticipated that this meeting will take place in November 2013. The Health Assembly is requested to note the report.

The SSFFC issue dates back to a controversy regarding WHO's association with IMPACT (International Medical Products Anti-Counterfeiting Taskforce). IMPACT arose out of a seminar in which the WHO was one of the partners, but which also included a very strong presence of the Pharma industry. Subsequently, through a process seen as non-transparent by many, the WHO commenced hosting of the IMPACT Sectt. This was objected to by many states (led by India and others) given the close association between IMPACT and the Pharma industry. There were also reservations that the Pharma industry, through IMPACT, was confusing the issue of 'counterfeit' – a trademark issue – with the issue of quality and safety, especially as regards generic drugs. The WHO subsequently has stopped functioning as the Sectt. of IMPACT and the member state mechanism on SSFFC was set up to clearly define different terms related to quality of medicines and demarcate these from issues of IP/trademark infringements. There, however, still continues to be divergent perceptions among member states as regards concrete ways to deal with the issue.

Summary of discussions

- Instead of looking for conceptual definitions, we need to develop a clear guidance for regulations in this area (Brazil)
- Proposed that the SC chair be chosen based on the principle of rotation (Brazil)
- The steering committee should be formally instituted so that efforts will be coordinated more efficiently. Meetings should be organized at regional level before the steering committee meeting.
- On behalf of AFRO – called for commitment to the presidency of the SC to the African region
- Eliminating these products is a top priority for African region. We have to be aware of the many challenges faced by our countries (Poor infrastructures, problems in regulatory authorities) and we have to be fully aware that there is not a simple solution for this problem,
- Concern with use of the term 'counterfeit' and need for common understanding of the meaning of SSFFC (India)
- Oppose linkage of WHO with IMPACT, in any way. (India)
- Supports proposal of Brazil regarding a steering committee chair by rotation. (India, Canada)
- Urge for cooperation to finalise issues, including question of presidency. Notes proposition from Brazil and will think about it. (Australia)
- The progress in the work of the mechanism is slow, quick advances are needed. There is also a lack of agreement on procedural issues, therefore disappointed by this process. Europe hopes that these difficulties can be overcome quickly. (EU)
- Each MS should nominate technical experts for the next meetings.
- Quick detection technologies (to detect SSFCs) should be emphasized
- Delays on decision on chairmanship has delayed the work decided in Buenos Aires (Tanzania)

- A system forcing ethical promotion of medicines and quality, safety and efficacy of data will strengthen safety. This can be achieved with off patent generic medicines. (Philippines)
- Should precise and widely adopted definitions of SSFFC, which should be compatible with international laws (China)
- Argentina supports USA, Brazil and India regarding a rotation of vice chairs
- Need an interstate policy and pooling of the information (Russian Federation)
- Need of strengthening the domestic regulatory mechanisms.
- Many MS expressed concern about delay in electing a chairperson for the steering committee.
- The internet facilitates trade of SSFCs
- International Alliance of Patients' Organisations recommended (in CS statement) building on the work of IMPACT (thus apparently aligning with the position of Pharma – *editorial comment*)

The assembly decided to recommend that the presidency of the SC of the MSM operates on basis of rotation for an interim period without change in the mandate of the MSM. Reference to vice chairs is not implicit in this proposition (Proposal by Brazil – adopted by Assembly)

17.4 The health workforce: advances in responding to shortages in migration, and in preparing for emerging needs

Document: (A66/25)

Background

The WHO Global Code of Practice on the International Recruitment of Heath Personnel was adopted at the 63rd World Health Assembly, in May 2010 in Resolution WHA63.16. In 2011, the WHA adopted two resolutions, on Health workforce strengthening (WHA64.6) and on Strengthening nursing and midwifery (WHA64.7). The adoption of the code marked the first time that MS used the constitutional authority of the WHO to develop such an instrument in thirty years. The Code was evolved in the context of a health workforce crisis in developing countries and aims to establish and promote voluntary principles and practices for international recruitment of health personnel. Resolution WHA63.16 provides that the first review of the relevance and effectiveness of the Code shall be made by the 68th WHA in 2015.

Summary of discussion

Under this agenda item the report gave an overview of the current situation in relation to health workforce migration, and delineated challenges for the future. The Assembly was requested to take note of the report.

Only few MS took part in the discussion on the report, reflecting the lack of ownership of MS to the Code. Few source countries mentioned facing a shortage of health workforce, but

failed to engage with the advantages and limitation provided by the Code. The health workforce crisis was not even mentioned.

During the elaboration of the Code the language was diluted in that the mention of compensation to source countries for the costs incurred in the formation of emigrated health workforce was removed. However, no country raised concerns on the impacts of this dilution on the implementation of the Code. This is despite that Resolution WHA63.16 provides for the possibility of proposals for the revision of the text of the Code in line with the first review, and based upon periodic reporting.

Since the adoption of the Code, the budget allocation to this issue has been decreased, compromising the capacity of the secretariat to instead ensure proper support for its implementation. The issue of the inadequate budget allocation was raised and MS requested support for the Organization for implementation of the Code.

Switzerland also raised that the successful implementation of the Code is a question of credibility of the WHO, especially as the Code is one of the few regulatory instruments developed and adopted by WHO over the last years.

Barbados suggested the creation of a health human resources observatory that could capture the complexities of health workforce migration.

The Statement presented by PHM and MMI can be accessed at: Statement by PHM and MMI on Code of Practice on the International Recruitment of Health Personnel.

The Assembly noted the report.

Item 17.5 eHealth

It was interesting to hear countries discuss their needs and concerns when it came to eHealth. There was a clear divide as to countries who have been able to implement standards and strategy around eHealth for research, data collection and information sharing.

Countries expressed concern that so few countries reported on their progress around eHealth and also that so few countries have implemented designated authorities to eHealth.

Developing countries, and others with minimal resources to devote to eHealth stressed the need for technical and financial assistance from WHO in acquiring or developing technology to begin to develop or increase their eHealth capacity. They expressed an understanding of interoperability and welcomed the idea of having standards around eHealth to promote such. Also noted was the necessity of having clinicians trained to set up infrastructure and use it so that it won't be done wrong. Further, attention was called to the fact that a lot of proprietary software does not meet the requirements set by WHO and would like to see one system that can work for data collection and reporting. that All delegates who spoke expressed agreement that WHO should lead this effort.

Countries who have already been able to make good progress around eHealth focused more on protecting the .health domain name and working with ICANN to secure high-level domain name. They stressed the importance to public health of securing .health. Misuse, even criminal use, of the domain name could result if it is not obtained, so Member States

urged WHO to ensure that there will be a framework for responding to bad acts if they arise.

The statement by Medicus Mundi International, Health Innovation in Practice and PHM stressed that securing the domain name is in the interest of global public health and to intensify action to ensure that the .health domain name is used for such.