

PHM / WHO Watch

Commentary on Issues coming before EB138 (Jan 2016)¹

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5.1 Overview of Reform Implementation

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In focus

The Secretariat has published a report ([EB138/5](#)) to the Board providing the following:

- an overview of the current status of reform;
- a review of progress made in the three broad reform workstreams; and
- information on the indicators that have been established to measure achievement of the reform objectives.

5.2 Member State consultative process on governance reform

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In focus

The report ([EB138/6](#)) provides details on the outcome of the Second Open Member States Meeting on Governance Reform, held in Geneva on 10 and 11 December 2015.

The mandate for this process covered:

1. working methods of the governing bodies; and
2. concrete ways to improve the alignment of the governance of all three levels of the Organization ([Decision EB136\(16\) \(2015\)](#)).

The December OMSMGR had before it the recommendations of the Working Group on Governance Reform in EB/OMSMGR/2/2 (30 November 2015) which is included as Appendix I in EB138/6.

The OMSMGR was able to agree on very few of the recommendations of the WG. See the bracketted onscreen text version of the recommendations included at Appendix II (from p38) for an indication of the lack of consensus.

The document before the Board has been prepared by the Chair of the OMSMGR on his own responsibility. It includes the Chairman's revised version of the recommendations of the WG.

Background

To access more of the documents of relevance to this process see:

- the [online platform](#) established to support the member state consultative process (MSCP)
- the 'homepage' for the [OMSMGR](#).

See also JIU reports:

- [Review of Management, Administration and Decentralization in the World Health Organization \(WHO\) - 2012 Part II](#)
- [Review of Management, Administration and Decentralization in the World Health Organization \(WHO\) - 2012 Part I](#)

- [Review of management and administration in the World Health Organization\(WHO\) - 2001](#)

PHM comment

The recommendations of the WG were constructive and practicable. The opposition to those recommendations, as reflected in the brackets in [Appendix II](#) is unfortunate.

It is to be hoped that the EB is able to project strong leadership in its advice to the Assembly on these recommendations.

However, the issues run deep.

Regional autonomy versus alignment of governing bodies

It appears that most of the opposition was to WG recommendations which might have been seen to reduce the autonomy of regional committees and regional directors.

Regional dysfunction consequent in part on the arrangements under which regional directors are appointed is a major disability for WHO. This was brought out particularly clearly in the report of the [Ebola Interim Assessment Panel](#) which was critical of the communication and judgement of the Secretariat including both regional and headquarters units. The Panel was also critical of the lack of compliance of member states with the requirements of the IHRs including both capacity development and breaches of the regulations through the imposition of illegal travel restrictions.

The dysfunctional arrangements for the nomination and appointment of regional directors has been commented upon repeatedly but MSs have repeatedly failed to address it.

WHO's regional system is unique among intergovernmental organisations. Undoubtedly there are important benefits which arise from this decentralisation. However there are also significant disabilities and there have been 'repeated but futile' ([Hanrieder 2014](#)) attempts to reform the way regionalisation works.

The findings of the most recent report of the Joint Inspection Unit ([JIU2012](#)) are worth reviewing:

The second main challenge to decentralization at WHO is the consistent implementation of policies, routine administrative services and related controls across the Organization. This is often a source of duplication, loss in economies of scale and inefficiency. ...

The powers vested by the Constitution in the Regional Directors as elected officials weaken the authority of the Director-General as chief technical and administrative head of the Organization, compared to other United Nations system organizations, and have been a source of tension in their relationship in the past....

Better defined monitoring and accountability mechanisms for Regional Directors are needed to monitor the implementation of the authority delegated to them and to assess their performance ... the accountability of managers is a critical issue in the perception of staff....

The two previous JIU reports on WHO examined this issue and its implications in detail. Particularly, JIU/REP/93/2 highlights that accountability is better exercised when based on a single, pyramidal chain of command and not with seven “executive heads”. It proposes to change the procedures for nominating Regional Directors – without changing the Constitution – to empower the Director-General to select them and nominate them for confirmation by the Executive Board, following consultations and in agreement with the Regional Committees. ...

At WHO ... Regional Directors are not subject to a formal performance assessment. ... The Inspectors are not aware of any performance appraisal of Regional Directors done by Regional Committees either.

The de facto election of regional directors (RDs) by the regional committees (RCs) is a major factor in the regional dysfunctions to which the JIU refers. The RD has a significant incentive not to challenge national health authorities because the RDs are themselves accountable to MSs for re-election. Ministers of Health may not welcome activist heads of WHO country offices (HWCOs) or RDs because of the risk that they may generate pressures causing political difficulties domestically. Conversely MOH officials may be less than confrontational with the RD if they are anticipating an appointment in the RO after leaving the MOH.

Both RD and MOHs have an incentive to caucus against HQ; arguing for larger share of budget and greater programmatic control. This includes caucusing against institutional reform which might weaken the region vis a vis the centre.

Clearly these dynamics do not operate in the same ways in all the regions. However, there is clearly a prima facie case for looking more closely at the processes for nomination and appointment of regional directors.

A recent review conducted by Chatham House in the UK ([Clift 2014](#)) commented that *... numerous external reports going back more than 20 years have identified key problems arising from the WHO’s unique configuration of six regional offices, with directors elected by member states, and its extensive network of about 150 country offices. While these reports have recommended sometimes radical reforms, there has been hardly any response from the WHO and its member states. This is because the governance structures in the WHO mean that there is a very strong interest in maintaining the status quo.*

Clift quotes Chow ([2010](#)) as commenting that ‘Regional leadership posts are pursued as political prizes’. Chow comments further

With competition between branches and body, the assignments of WHO country representatives often involve extensive negotiations between the power in Geneva and the power in the region. Key appointments have many a time been blocked not by qualifications of the individuals but for political reasons.

Clift refers to the 1993 JIU report which:

... identified the way in which RDs were elected by their regional committees as the central problem. But the JIU’s proposals, seeking to depoliticize the regional committees by reasserting the authority of the EB and the director-general in the appointment of RDs, were not taken up by the EB.

Chow argues strongly for Country Offices working with a range of stakeholders including local health workers and civil society as well as the ministry of health. It seems that while the RD is beholden to the MOH for election he/she is unlikely to countenance such an extension of country office work, even if it would make the Organisation more effective.

The JIU report of 2012 commented that:

WHO participation in multi-sectoral health programmes and activities at country level should be rendered more effective. To this end, WHO country offices should be provided with improved guidance, tools and possibilities and HWCOs empowered to be operative and capable partners. ...

The reluctance of MS to reform the central regional relationships in the context of the OMSMGR process points towards continuing dysfunction.

Lack of member state accountability

Collectively WHO's MSs are responsible for the proper funding of WHO. Collectively they have failed this responsibility. Collectively MSs are responsible for the coherent functioning of all three levels of the Organisation. Collectively they have failed this responsibility.

Individually MSs are responsible for the quality of policy analysis underpinning their contributions to governing body debate. Not all MSs live up to this obligation. More importantly MSs should be accountable for implementation of governing body resolutions, which they are not. The limited implementation of the Code on the Marketing of Breastmilk Substitutes and the continuing gaps in the achievement of core capacities under the IHRs illustrate the point.

In the context of the Ebola crisis the disregard of their obligations regarding 'additional measures' under the IHRs by certain MSs illustrates. However, the disregard by member states of their obligations under a wide variety of resolutions, strategies and plans. Of course MS have the right not to implement such but they should be asked to account for what they have or have not done.

The repeated emphasis on the voluntary nature of MS obligations within WHO stands in sharp contrast to the binding commitments with serious sanctions being implemented through plurilateral trade agreements. Notwithstanding the Doha Declaration of 2001 it appears that the trade interests of powerful countries overrides the health goals arising from the WHO Constitution. .

There has been an extended discussion over recent years of the importance of protecting the integrity of the WHO from conflicts of interest arising from experts who provide advice or the institutions with whom WHO collaborates. However, there have been some quite high profile instances where lack of accountability on the part of MS has significantly undermined the integrity of WHO. See our WHA68 commentary under NSAs ([here](#)) regarding a number of such cases.

There are models in other intergovernmental organisations which could be used to strengthen the accountability of MSs to their peers, preferably from beyond their region. These include the universal periodic reviews held by the Human Rights Council, the periodic reporting of the World Heritage Committee and IMF, OECD and WTO trade policy reviews.

Ultimately the constituency, to which MS officials are presumed to be accountable, is the domestic electorate and there are precedents (NCDs, tobacco control, breastfeeding) which illustrate the possible roles which could be played by professional constituencies and community based organisations in mediating more firmly such accountability. However, to fully recognise the power of domestic civil society in health development might make ministers uncomfortable.

The barriers to coordination and collaboration within the Secretariat arising from the intra-organisational competition for donor attention and donor funding consequent on organisational donor dependence due to the freeze on assessed contributions

The suspicion, disregard or neglect with which member states treat WHO is nowhere more evident than in relation to the freeze on assessed contributions and the refusal of donors to untie their donations.

This has had direct impact on the coherence of WHO's programmes.

WHO's dependence on donor financing has led to donor capture of WHO's operational agenda; with gross misalignments between priorities identified in the Assembly and expenditures underwritten by donors.

Equally destructive has been the competition for donor funds between clusters, departments and regions. Departments are forced to compete for opportunities for visibility, including workshops, publications, projects and governing body resolutions. Not surprisingly collaboration suffer when colleagues are seen as competitors.

Beyond donor capture and the fragmenting effect of internal competition, is the fact that WHO's budget is in absolute terms quite inadequate. [Kickbusch \(2013\)](#) notes that the annual budget of WHO is comparable to that of the Geneva Cantonal Hospital and she compares the miniscule WHO budget to the global cost of SARS, the increased funding which China has allocated to rebuilding rural medical care and the huge budgets of the Global Fund and the Gates Foundation. It is clear that WHO's response to the Ebola crisis was severely restrained by the continuing freeze on assessed contributions ([Gostin and Friedman 2014](#)).

WHO's role in the wider structures of global health governance and global governance for health

There have been occasional references, during the discussions of WHO reform, to WHO's leadership and coordination role in relation to the various other bodies which participate in global health governance. These include other intergovernmental bodies, global health partnerships and global private sector entities (including philanthropies, corporations and business associations).

The direction of these references range from those who remember the Article 2(a) from the WHO Constitution ('to act as the directing and coordinating authority on international health work') to those who blame WHO for the emergence of various other agencies and organisations.

PHM belongs to the former group and sees WHO as the pre-eminent global health authority, notwithstanding the freeze and the organisational dysfunctions referred to above.

PHM believes that it is time for WHO to take concrete steps to fulfil the obligations imposed by Article 2(a). We suggest that the adoption by the UN of the new Sustainable Development Goals provides an opportunity for WHO to project such leadership.

We envisage a resolution commissioning the Secretariat to report annually on the health dimensions of each of the 17 new SDGs. This annual report would include:

- a review of the global organisations who are in a position to advance the population health outcomes associated with each of the goals and an assessment of achievements and shortfalls in the work of each of those organisations;
- a review the achievements and shortfalls of member states in relation to the population health outcomes associated with each of the goals with recommendations for strengthening such work.

5.3 Framework of Engagement with NSAs

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In focus

The Secretariat will report ([EB138/7](#)) on the outcome of the open-ended intergovernmental meeting convened in line with resolution [WHA68.9](#) (2015).

The EB is requested to extend the mandate of the OEIG meeting to finalise the Framework. It seems unlikely that the EB will engage with the substance of the Framework under development as reflected in EB138/7.

Background

Secretariat [resources page](#) (extensive).

PHM commentary prior to [WHA68](#)

PHM report of discussion at [WHA68](#)

Provisional summary records of FENSA discussion at WHA68

- First meeting: [page 6](#) (one para)
- Fourteenth meeting: [page 2](#) (one para)
- Fifteenth meeting: [page 3](#)-44: bracketted text; 44-51: debate;
- Resolution [A68.9](#) adopted

CSO Letter to DG (15 Oct 2015) [Civil Society Letter of Concern on FENSA “non-paper”](#)

Third World Resurgence: [World Health Organization-Corporation?: Resisting Corporate Influence in WHO](#)

[WHO: Informal meeting to negotiate text on engagement with non-State actors](#) (TWN Info Service on Health Issues, 19 October 2015)

[WHO: Secretariat “scare mongering” on FENSA](#) (TWN Info Service on Health Issues, 19 October 2015)

[WHO - Partial agreement on engagement policy with industry](#) (TWN Info Service on Health Issues, 26 October 2015)

Medicus Mundi International [WHO Reform repository](#)

PHM comment

There is much more green than there was at WHA68 and after the July meeting. It seems possible that an agreed document will be produced.

Among the issues which are still lacking consensus:

- the proposed pooling method for private sector entities (PSEs) to contribute financially to WHO;
- technical collaboration.

The final 'consensus draft' which comes out of this process will be considered at WHA69. It is most unlikely that it will be opened for amendment!

6.1 Maternal, infant and young child nutrition

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In focus

The Secretariat's report ([EB138/8](#)) responds to requests contained in the following:

- decision [WHA67\(9\)](#) (2014),
- the Comprehensive implementation plan on maternal, infant and young child nutrition endorsed in resolution [WHA65.6](#) (2012),
- the [International Code of Marketing of Breast-milk Substitutes](#) adopted in resolution WHA34.22 (1981) and
- resolution [WHA61.20](#) (2008).

The report advises the Board on:

- progress made in the implementation of the Comprehensive implementation plan on maternal, infant and young child nutrition;
- the [International Code of Marketing of Breast-milk Substitutes](#); and
- progress in consideration of matters referred to Codex Alimentarius for action.

The Secretariat also reports on the outcome of the consultation on identifying and managing conflict of interest in relation to nutrition issues. See the [report of the COI consultation](#). The consultation appears to have been quite successful in delineating key issues and suggesting tools for risk assessment and management. There appear to be no specific recommendations for carrying forward the issues identified through the consultation, either in the report of the consultation or in EB138/8.

EB138/8 also reports on the findings of a Scientific and Technical Advisory Group (STAG) on inappropriate promotion of foods for infants and young children. The report presents a set of recommendations on approaches to limit the inappropriate promotion of foods for infants and young children and a draft resolution for EB consideration.

Background

See some of the background to this item summarised in [PHM's commentary on Item 13.2 from WHA68](#).

This item overlaps with the SDGs (see PHM commentary on the SDGs under [Item 7.2 on this agenda](#)).

It also overlaps with the implementation of the outcomes of ICN2 and the evolving UN Nutrition System. See:

- PHM commentary on [Item 13.1 \(ICN2\) of WHA68](#);
- PHM commentary from WHA67 regarding:
 - [COI in Nutrition](#),
 - [GAIN and ISDI](#),
 - [Draft outcomes document for the Second International Conference on Nutrition](#).

The food crisis has complex determinants including:

- the realities of hegemonic global production, distribution, marketing and consumption system that neglects small producers;
- the political economy of a vertically integrated global food production and supply system;
- governance structures which constrain the development of a small farmer based and ecologically sustainable global food production and supply system;
- a lack of integration of nutrition considerations in food security approaches.

Global Health Watch is a good starting place for further analysis. Every issue of GHW since 2005 has commented on the food and nutrition crisis (see [GHW3](#), [GHW2](#), [GHW1](#) and [GHW4](#)). See also [Food First](#), [FIAN](#), [IATP](#), [Via Campesina](#).

PHM comment

Progress in implementing the Comprehensive Implementation Plan

The degree of 'progress' in relation to the five targets (stunting, anaemia, low birth weight, overweight and breastfeeding) has been very slow and in some cases going backwards.

At a general level the Actions identified for the CIP are sensible but they are largely cast in general terms and do not appear to have progressed very far.

It appears that progress in developing and implementing national plans has been particularly slow. The national plan must deal with major intersectoral issues and such whole-of-government policy work is always hard. However there are also powerful industries watching very closely and ready to intervene to protect their interests.

PHM is very concerned about WHO's reliance of SUN for providing support to countries. SUN includes corporations and business organisations which are deeply invested in national food systems. Indeed one of the functions of SUN's Business Network is to recruit more business organisations to the SUN network. It is unfortunate that SUN was not considered as a case study in the Technical Consultation on COI in Nutrition.

PHM urges WHO at global, regional and country level to invest more in working with civil society networks to strengthen the political demand for effective national plans and for full implementation.

The work of the CFS in following up the recommendations of ICN2 is appreciated. However, these recommendations were disappointing in many respects. See [PHM Comment on ICN2](#) at WHA68.

The barriers to food security and food sovereignty in current trade and investment agreements need to be clearly addressed. **PHM urges staunch opposition to the use of ISDS to prevent effective regulatory strategies.** We urge a return to multilateral negotiations around trade in agricultural commodities to ensure the elimination of dumping and of protection and subsidies to corporate agriculture. WHO has a mandate (through [WHA59.26](#), page 37) to take the lead in this work. UN SCN has committed to a policy document on trade and nutrition.

There are deep conflicts between the assumptions underlying the food sovereignty movement, which envisages food and agricultural systems based on agroecological principles (see PICS&SM [statement](#)), in contrast to the globalised corporate industrial model of corporate agriculture and corporate dominated food systems. **PHM calls for a new Commission to be jointly sponsored by WHO and FAO to investigate and report on the role of food sovereignty in addressing the challenges of food security.**

The increasing power of transnational corporations vis a vis the democratic expression of the public interest is widely recognised. There is an urgent need for new international instruments to regulate the TNCs in areas where their profit objectives run counter to public policy objectives such as food sovereignty and environmental sustainability. **PHM calls on WHO to open negotiations with UNCTAD and HRC with a view to exploring in more detail possible strategies for regulating TNCs** (see PICS&SM statement).

Access to decent food, consistent with cultural traditions, is a basic human right (see [OHCHR](#)); the human rights perspective must permeate all policies and actions in this field. **PHM urges WHO to work with the Special Rapporteurs on the Right to Food and the Right to Health in preparing an information product on the human rights dimension of food and nutrition policies, and particularly the Outcomes commitments of the ICN2, designed to inform national nutrition planning.**

It is self-evident that governments by themselves are not able (and in some cases not willing) to put in place the necessary national and international reforms needed to guarantee the right to food (as articulated by the Special Rapporteur on the Right to Food). Civil society and social movements have a critical role to play at both the national level and international level. **PHM calls for member states (both individually and through WHO) to recognise the powerful role that CSOs play in defending the RTF and decent nutrition and advancing the principles of food security through food sovereignty** and to explore ways of working productively to this end at both the national and global levels.

Progress in implementing the Code

We regret the slow rate of progress in the implementation of the Code. Only 47 countries have adopted legal measures; only 27 countries are monitoring outcomes; political commitment is weak.

The lack of accountability of member states for implementing WHO resolutions is one of the core weaknesses of WHO, unfortunately not being addressed in the current reform programme.

Conflict of interest regarding nutrition programmes

The report of the Technical Consultation is rich with insights and suggestions.

Unfortunately there is no recommendation before the EB directed to giving authoritative status to the findings of the consultation and putting in place appropriate programs and regulatory structures.

Ending inappropriate promotion of foods for infants and young children

The STAG reports that inappropriate promotion is happening widely.

The draft guidance document in the Annex to EB138/8 includes some very useful ideas. The annex is supported by a draft resolution requesting implementation action from governments, manufacturers and distributors, health care professionals, media and creative industries, civil society, and the Director General.

PHM urges MS to consider strengthening this draft resolution through including references to the bolded passages above.

6.2 Draft global plan of action on violence

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In focus

The Secretariat report ([EB138/9](#)):

- summarises the consultation processes which have been undertaken around the proposed Global Plan of Action;
- presents a draft resolution for the EB to forward to the WHA69 endorsing the Global Plan of Action;
- reports on the formal meeting of MSs (Nov 2015) to finalise the development of the Global Plan of Action;
- presents the most recent draft of the proposed Global Plan of Action.

The focus of discussion will be the proposed Global Plan of Action and the draft resolution.

Background

WHO produced the [World report on violence and health](#) in 2002 and its recommendations endorsed in [A56.24](#).

See [WHO topic page on Violence](#).

Violence appeared on the EB134 agenda (Jan 2014) 'at the request of a member state'. (Work on the Global Status Report was underway at this time.) See:

- PHM [commentary](#)
- Secretariat report ([EB134/21](#))
- Record of debate ([13th meeting](#))
- Decision [EB134\(6\)](#)

Some of the key issues in contention during this discussion include: marital rape, female genital mutilation, dowry violence, rape, sexual abuse and references to the human rights and freedoms of women and girls.

It returned to WHA67 (May 2014) as Item 14.3. See:

- [PHM commentary](#)
- Secretariat report ([A67/22](#))
- Record of debate
 - [Committee A, First Meeting](#)

- [Committee A, Twelfth Meeting](#)
- [WHA67.15](#)

After long and difficult negotiations WHA67.15 was adopted. One of the sticking points before adoption was the reference to 'intimate partner violence'. It was required that 'intimate' be removed.

The [Global status report on violence prevention 2014](#) was jointly published (December 2014) by WHO, UNDP and UNODC (office on drugs and crime).

At the national level, the report's key recommendations are:

- to improve data collection in order to reveal the true extent of the problem
- to draw up comprehensive and data-driven national action plans
- to integrate primary and secondary violence prevention into other health platforms
- to strengthen mechanisms for leadership and coordination
- to ensure prevention programmes are comprehensive, integrated and based on evidence
- to ensure that services for victims are comprehensive and informed by evidence
- to strengthen support for outcome evaluation studies
- to enforce existing laws and review their quality
- to implement and enact policies and laws relevant to multiple types of violence
- to build capacity for violence prevention.

At the regional and global levels, the report's key recommendations are:

- to strengthen the global violence prevention agenda
- to increase support for comprehensive and integrated violence prevention programming
- to strengthen efforts of regional and subregional organizations to work with national offices to coordinate data collection and disseminate data gathered
- to increase collaboration between international organizations and donor agencies
- to set baselines and targets, and track progress.

Violence returned to EB136 (Jan 2015) as Item 6.5. See:

- PHM [commentary](#)
- Secretariat reports: ([EB136/12](#), [EB136/12 Corr.1](#))
- [Record of debate](#)

The Secretariat report introduced the Global Status Report and proposed the development of a global plan of action. There was appreciation of the Global Status Report and the proposed process and timelines were agreed to.

EB138/9 describes the consultation process from EB136 onwards (paras 2-4).

PHM comment

In many respects this is an excellent Global Plan of Action. It is comprehensive, evidence based and strongly informed by humanistic principles.

There are a few disappointments which reflect 'cultural differences' among the member states.

Neither patriarchy (nor sexism) are mentioned although unequal power relations is included under Guiding Principles and women's empowerment is mentioned repeatedly and there is a reference to SDG5 in Appendix 6.

Neither race nor caste nor sexual orientation are mentioned explicitly although there are references to 'vulnerable groups' and 'discrimination'; see para 23 and in the Vision. This is a shameful compromise; violence against gays, lesbians, bisexuals, queers and transsexuals is widespread.

Clearly the authors of the text have sought to get as close to such realities as possible. See Principle 9 "*Listen to the needs of communities*". See also para 9 and 10 on page 17.

However, to not mention communities of race or caste or of sexual orientation is a lapse in solidarity.

6.3 Prevention and control of NCDs: responses to specific assignments in preparation for the third High-level Meeting of the UNGA on the Prevention and Control of NCDs in 2018

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In focus

The report before the Board ([EB138/10](#)):

- describes progress made between 2013 and 2015 in implementing the WHO [Global Action Plan](#) for the prevention and control of noncommunicable diseases 2013–2020 ([Annex 1](#));
- proposes a process for updating [Appendix 3](#) of the GAP which sets out policy options and tools for achieving the nine global targets ([Annex 2](#));
- describes progress made in 2015 towards attainment of the nine global targets ([Annex 3](#));
- describes the proposed development of an approach to register and publish the contributions of NSAs (PSEs, philanthropies, CSOs) towards the achievement of the nine global targets ([Annex 4](#));
- foreshadows the development of a technical paper on the tracking of development assistance for NCDs for WHA69 ([para 7](#));
- reports on progress in implementing the [workplan of the Global Coordinating Mechanism](#) in 2014/15 ([Annex 5](#));
- reports on progress achieved by [Inter-Agency Taskforce](#) (in [Annex 6](#));
- sets out the contours of a report to the UNGA in late 2017 on implementation of the 2011 Political Declaration ([UNGA66/2](#)) and the 2014 Outcomes Document (UNGA [68/300](#)) (in [Annex 7](#)).

The report also:

- reviews ([para 11](#)) the four time bound commitments to which Ministers are committed (through the 2011 Political Declaration ([UNGA66/2](#)) and the 2014 Outcomes Document ([UNGA68/300](#)));
- refers to the [WHO NCDs Progress Monitor 2015](#) through which national progress regarding the four time bound commitments is being measured and reported;
- presents a diagram which seeks to integrate the various policies, strategies, commitments and targets adopted at the national and global levels ([Fig 1](#)).

Finally, the report proposes a draft resolution ([para 14](#)) for the EB to consider submitting to WHA69. The proposed resolution endorses and enacts the proposals and exhortations presented elsewhere in the report and summarised above.

The mandate for the Secretariat's work on these various projects is given by:

- the Health Assembly (in [WHA66.10](#), 2013);
- the Political Declaration of 2011 (United Nations General Assembly resolution 68/300, see Annex 1 of [A68/11](#)); and
- United Nations Economic and Social Council resolution [2014/10](#) regarding the Inter-Agency Task Force.

The mandate also includes [SDG3](#) ("Ensure healthy lives and promote well-being at all ages") including the 13 health targets for 2030. WHO has [argued](#) that there are health implications arising from many of the other 16 goals.

The context for this report to the Board also includes the Secretariat's preparation for the third High-level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases, scheduled to be held in 2018.

Background

Global policy and decision making around NCDs has become very complicated with multiple overlapping mandates and forums of discussion/decision. The fundamental issues are at real risk of getting lost amidst the forest of documents, resolutions, objectives, commitments and indicators.

Nevertheless the politics of (non) decision making around NCDs is reflected in the history of this forest.

References to previous documents, and some analytical commentary can be found in the:

- PHM comment on [Item 7](#) (Sugar Guidelines) at EB137 (May 2015);
- PHM comment on [Item 13.4](#) (NCDs omnibus) at WHA68 in May 2015;
- PHM comment on EB136 (Jan 2015): [Items 6.1](#) (ICN2), [6.2](#) (Maternal and Young Child Nutrition), [6.3](#) (Ending Childhood Obesity), and [6.4](#) (Follow up of 2014 HLM on NCDs); and
- the PHM comment on [Item 13.1](#) (NCDs omnibus) at WHA67 (May 2014).

A range of useful resources can be accessed WHO's NCDs [topics page](#) and the NCDs & Mental Health [programmes page](#).

PHM comment

PHM comments on specific Secretariat documents included in EB138/10

[Annex 1](#). Implementation of Global Action Plan

This annex reports on progress at the National level; progress made by International Partners (development assistance donors) and civil society; and progress made by the Secretariat under each of the six objectives of the GAP.

The indicators purporting to measure progress in national capacity are highly questionable. It is not clear that the questions in the questionnaire are being interpreted in a uniform way by national respondents. It is not clear that the institutions and programs reported by respondents in response to specific questions have comparable levels of effectiveness in practice.

The culture of self-reporting by member states in WHO reflects a deep flaw with respect to MS accountability and a barrier to WHO effectiveness. It is a serious weakness of the WHO Reform Program that there has been no move to a more independent and more discerning reporting and review system such as operates in OECD, IMF, WTO and HRC, all of which deploy peer review systems.

In reporting Secretariat action there is no reference to the gross underfunding, under the Financing Dialogue, of WHO's NCDs work. See Fig 1 in [A68/6](#). It is apparent that notwithstanding their rhetoric about the importance of NCDs the big bilateral donors do not want to see progress in this area.

Likewise there is no reference to trade, tax, or the regulation of TNCs (other than tobacco). We appreciate the reference to capacity building in accordance with WHA59.26 in para 11 but this appears to apply only to tobacco.

[Annex 2](#). Process for updating Appendix 3 of the GAP

Appendix 3 of the GAP comprises a list of evidence based policy options and interventions to support the achievement of the six objectives of the Plan. It was intended that this appendix would be reviewed periodically to ensure it remains abreast of contemporary evidence.

PHM urges the Secretariat to consider closely the need for trade and health policy coherence and the development of trade and health policy capacity in the revision of this appendix. We urge the inclusion of guidelines for health impact assessment of trade agreement provisions.

By way of illustration we refer to the secret TTIP negotiations currently underway threatening significant weakening of consumer safety standards. The introduction of investor dispute settlement provisions threaten to limit the power and responsibility of national parliaments.

[Annex 3](#). Progress in attaining the nine voluntary global targets

Annex 3 presents global data for 18 indicators designed to measure progress towards the nine voluntary global targets. Some data for 2010 and 2014 are presented.

Many of the putative indicators have no data available but there is no discussion of the barriers to collection. Is this lack of funding? It is because the global targets are 'voluntary'? Perhaps the collection of data is also 'voluntary'. Because of burden of disease in question the voluntariness of data collection needs to be urgently reframed in international health legislation.

There is no reference to methods for statistical evaluation of the differences between 2010 and 2014 for those targets for which data are available.

[Annex 4](#). Contributions of NSAs to the nine global targets

Para 37 of UNGA [68/300](#) (July 2014) calls upon WHO to put in place a register which can be used to publicise the 'contributions' of private sector entities, philanthropies and civil society organisations to the achievement of the nine global targets.

This appears to be a very silly commitment. There is no discussion in [68/300](#) of the purpose of this provision. There is no argument presented along the lines of strengthening accountability or improving coordination and proposed procedures do not appear to offer any such benefits.

The main motivation for private sector entities to seek registration would appear to be the public relations benefits to be gained therefrom. The transaction costs of handling this publicity platform will be burdensome for WHO and not consistent with the emerging FENSA principles.

PHM urges that the concept of 'contribution' be recognised as having positive *and* negative interpretations and that there should be scope for independent registrations of the negative contributions to the nine global targets by PSEs.

If a register of PSE 'contributions' were to make a contribution to public policy it would need to have some representational quality (in the sense of being a valid reflection of the field as a whole) to enable useful analysis rather than simply the wish of particular PSEs to be registered.

There may be some merit in registering the contributions of philanthropies if this is undertaken in a comprehensive and independent way. Such registration could help to hold philanthropies to account for the approach adopted, could encourage more effective strategies, and could support more effective coordination of different funding agencies.

PHM sees no purpose in registering 'contributions' of CSOs. Rather PHM urges that CSOs take up this opportunity to register the contributions, positive and negative, of PSEs and philanthropies.

PHM urges the WHO Secretariat to assign a very low priority to progressing this project.

[Annex 5](#). Progress in implementing the workplan of the global coordination mechanism ([GCM](#))

Annex 5 presents a very brief summary of Secretariat action on eight action areas from the workplan of the GCM.

Three of these deal with the interface between development assistance and action around NCDs. Two dialogues and a web-based platform are reported. An initiative to disseminate best practice in intersectoral collaboration is reported. A series of webinars ‘to support the coordinating role of WHO’ is reported. A community of practice has been established (within the Secretariat).

Two working groups and their interim reports are reported on, dealing respectively with:

- Action 3.1: How to encourage the private sector to strengthen its contribution to NCD prevention and control ([para 44 of 2011 Political Declaration](#)); an interim report is published ([WG3.1](#)) and [responses](#); a final report is due to the DG by end 2015;
- Action 5.1: How to realise the commitment in [para 45\(d\) of the Political Declaration](#) to ‘explore the provision of adequate, predictable and sustained resources, through domestic, bilateral, regional and multilateral channels, including traditional and voluntary innovative financing mechanism’; an interim report is published ([WG5.1](#)) and [responses](#) and a final report is due with the DG by end 2015.

Action 5.1 concerns resource mobilisation for NCD responses. The Interim Report (i) acknowledges that such responses will have to rely primarily on domestic public resources; (ii) calls for more effective and scaled up ODA for NCDs action; (iii) recommends promoting investment by PSEs in areas critical to NCD control; and (iv) urges more philanthropy in this area.

Rec (v) is a useful reminder of the importance of addressing the coherence and consistency of financial, investment, trade, development and public health policy as a condition for mobilising sufficient funds for action on NCDs. The WG refers to [para 30\(a\)\(vi\) of UN 68/300](#) and recommends consideration of:

- Strengthening safeguards in investment treaties to protect public health;
- Strengthening policy coherence between development, health, finance and trade sectors; and
- Promoting better alignment between existing multi-stakeholder partnerships, such as The Global Fund and GAVI, with a view to encourage them to improve their contribution to health system strengthening and universal health coverage in way that would also ensure better health outcomes for NCDs.

Currently, there is no procedure in place to ensure that recommendations of the Working Groups are reported to the governing bodies of WHO. PHM calls upon MS to request that a formal process is put in place to ensure that WG recommendations be reported to the governing bodies.

The inclusion of investor state dispute settlement provisions in new trade agreements, such as the Trans Pacific Partnership (TPP) and presumably also the Trans-Atlantic Trade and Investment Partnership (TTIP), is of particular concern. These provisions provide a powerful weapon in the hands of transnational corporations to intimidate governments, in particular the governments of smaller L&MICs.

WHO has a mandate (through [WHA59.26](#)) to take the lead in this work, and not just in relation to tobacco or pharmaceuticals.

Conflict of interest

PHM notes the lack of any commitments in the GCM workplan to address the influence of big pharma, big food and big beverage on WHO and UN policy making around NCDs and points to the importance of managing effectively the risk of improper influence in relation to NCDs policy making.

During the recent GCMNCD dialogue meeting on international cooperation, that took place on 30 November and 1 December, participating civil society organisations have alerted the GCMNCD secretariat to the risks regarding conflicts of interest, the lack of transparency in the modalities for participation, and the failure to identify who is who in the meeting. Similarly, it was highlighted that the selection process for Working Group members is not transparent and should be opened up for inputs from civil society. For future dialogues and on-line platforms and communities of practice, a coherent and transparent system of constituencies and related rules and procedures ought to be in place.

Transparency is only a first step though, and PHM urges that an additional function to be assigned to the GCM to monitor potential conflicts of interest in the policy processes associated with the Global Action Plan and to advise the DG where conflicts of interest may lead to improper influence in such policy processes.

[Annex 6](#). Progress of the [Inter-Agency Taskforce](#)

Annex 6 reports:

- joint country programming missions involving ‘interested organisations’ of the UN system;
- development of three joint global programs;
- the development of the 2016/17 workplan; and
- concern about collaborative and funding relationships between certain members of the Taskforce and the tobacco industry.

Regulation of TNCs

PHM calls on WHO to open discussions with the Human Rights Council regarding the proposed internationally legally binding instrument on TNCs and other business enterprises ([A/HRC/26/L.22/Rev.1](#)) with a view to developing a global joint program on the regulation of TNCs within the IATF, focusing on the regulation of foods and beverages in the first instance.

The increasing power of transnational corporations vis a vis the democratic expression of the public interest is widely recognised. There is an urgent need for new international instruments to regulate the TNCs in areas where their profit objectives run counter to public policy objectives such as food sovereignty and environmental sustainability.

Pharmaceutical innovation

PHM calls upon WHO to open discussions with appropriate members of the IATF (UNAIDS, UNICEF, IARC, etc) regarding a global joint programme on alternatives to market driven R&D and IP protected monopoly pricing as drivers of pharmaceutical research and innovation. This model is driving the prices of treatments for NCDs, such as cancer and autoimmune diseases, to absurd levels; to the point where public procurement or reimbursement programs, even in rich countries, are unable to offer such treatments.

Proposed amendments to the draft resolution

PHM proposes the following amendments to the draft resolution (at [para 14 of EB138/10](#)):

- OP1: NOTES the process to update, in 2016, Appendix 3 of the global action plan for the prevention and control of noncommunicable diseases 2013–2020;
- OP2: ENDORSES the process to further develop, in 2016, an approach that can be used to register and publish contributions of non-State actors to the achievement of the nine voluntary global targets for noncommunicable diseases; including provision for independent nomination and provision for negative contributions to be nominated;
- New OP2 (bis): DECIDES to add to the TOR of the GCM a mandate to monitor potential conflicts of interest arising in the implementation of the Global Action Plan and to advise the DG where conflicts of interest may lead to improper influence on policies and programmes;
- New OP3 (bis): URGES donors to WHO (especially donor MS) to untie their donations to WHO so that action on NCDs can be properly funded;
- OP4. REQUESTS the Director-General:
 - OP4.1: to submit an updated Appendix 3 of the global action plan for the prevention and control of noncommunicable diseases 2013–2020, through the Executive Board, to the Health Assembly in 2017, in accordance with the timelines contained in Annex 2 of the report; and to give close attention to trade and health policy coherence and the development of trade and health policy capacity including the development of guidelines for health impact assessment of trade agreement provisions in the revision of Appendix 3;
 - OP4.2 to submit an approach that can be used to register and publish contributions of non-State actors, through the Executive Board, to the Health Assembly in 2017, in accordance with the timelines contained in Annex 4 of the report and providing that negative contributions can also be nominated.
 - New OP4.3 to submit to EB139 proposals to progress recommendation 5 of WG5.1 (as reported in Annex 5) viz:
 - Strengthening safeguards in investment treaties to protect public health;
 - Strengthening policy coherence between development, health, finance (including taxation) and trade sectors; and
 - Promoting better alignment between existing multi-stakeholder partnerships, such as The Global Fund and GAVI, with a view to encourage them to improve their contribution to health system strengthening and universal health coverage in way that would also ensure better health outcomes for NCDs.

- New OP4.4: to ensure that recommendations made by the Working Groups under the GCM be reported to the WHO governing bodies;
- New OP4.5: 'to open discussions with the Human Rights Council regarding the proposed internationally legally binding instrument on TNCs and other business enterprises ([A/HRC/26/L.22/Rev.1](#)) with a view to developing a global joint program on the regulation of TNCs within the IATF, focusing on the regulation of foods and beverages in the first instance;
- New OP4.6: 'to open discussions with appropriate members of the IATF (UNAIDS, UNICEF, IARC, etc) regarding a global joint programme on alternatives to market driven R&D and IP protected monopoly pricing, as co-drivers of pharmaceutical research and innovation.

6.4 Public health dimension of the world drug problem including the Special Session of the UNGA, to be held in 2016

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- [In focus](#)
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- [PHM comment](#)
- [Notes of discussion at EB138](#)

In focus

At the request of several Member States, the Secretariat will provide information ([EB138/11](#)) on the 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, which is scheduled to be held in April 2016.

(It is not clear why this report was published so late, less than two weeks before the EB meeting.)

The report canvasses key issues for a public health consideration of ‘the world drug problem’ including:

- . prevention of drug use and reduction of vulnerability and risks
- . treatment and care of people with drug use disorders
- . prevention and management of the harms associated with drug use
- . access to controlled medicines
- . monitoring and evaluation

The Board is invited to note the report.

A resolution may be under preparation..

Background

The [Political Declaration and Plan of Action on International Cooperation towards an Integrated and Balanced Strategy to Counter the World Drug Problem \(2009\)](#) will be reviewed at the April UNGASS (above).

For more background see WHO [Management of Substance Abuse website](#).

PHM comment

This is an excellent report and should form the basis for a strong resolution.

Nevertheless, the analysis needs to be strengthened in certain areas.

The section on primary prevention is largely about prevention strategies and programmes tailored to the age of the target population, risk levels and the settings in which the interventions are planned to be delivered.

There is a reference in para 7 of EB138/11 to the need for action on the social determinants of drug use including unemployment and marginalisation but not much which reflects on causes of widening inequalities, intergenerational unemployment and deep alienation which contribute to communities who are predisposed to deploy mind altering substances to reframe their realities.

It is interesting to return to the Statement by the United Nations Under-Secretary-General and Executive Director of the United Nations Office on Drugs and Crime, Mr. Antonio Maria Costa which introduces the [2009 Political Declaration](#).

... the largest share of the world's drug trade and abuse can be traced to a few blocks, in a few neighbourhoods of a few big cities. The key to regaining control of these areas is for law enforcement, combined with social reintegration, to create viable alternatives for young people who are lost to addiction, or who have become urban child soldiers of crime syndicates. In a rapidly urbanizing world, drug control will be won, or lost, in the cities.

The world faces a rolling global economic crisis including a growing imbalance between productive capacity and effective consumption. The neoliberal response to this imbalance is to drive (through so-called 'free' 'trade' agreements) a process of global economic integration with a view to protecting the interests of powerful transnational corporations even though it contributes to a further widening of inequality and increases the numbers of excluded and marginalised. Talk about 'reintegration of marginalised people into their communities' in this context belongs to a parallel fantasy world.

The drug cartels use the same covert channels and havens for moving money globally as the big corporations use to avoid paying tax. However, the leading capitalist powers continue to stall on a multilateral agreement on taxation.

Another quote from Mr Antonio Maria Costa directs our attention to the role of imperial destabilisation and overt warfare in creating the conditions for drug trafficking.

While ghettos burn, West Africa is under attack, drug cartels threaten Central America, and drug money penetrates bankrupt financial institutions,

The role of the imperial powers forcing opium onto the Chinese is perhaps the most notorious example of imperial adventures in creating the conditions for drug trafficking or even promoting drug markets. However, it is not a unique case, nor is the practice of purely historical interest.

There is a long history of imperial interference in Central America and in the Eastern Mediterranean which has in many ways created the conditions for illicit drug cultivation and trafficking.

An exclusionary and unfair trade regime in agricultural products, designed to support Northern agribusiness, contributes to driving some farmers in unstable and conflict zones to consider growing illegal crops.

There is a useful discussion of harm reduction in EB138/11 but no explicit mention of decriminalisation including for example safe injection facilities. This is too cautious.

There is an urgent need for a strong resolution to give authority to the public health perspective in the UNGASS in April. EB138/11 provides the basis for such a resolution. It would add a sense of reality to such a resolution to include some recognition of the additional issues referred to above.

6.5 Addressing the challenges of the UN Decade of Action for Road Safety (2011–2020): outcome of the Second Global High-level Conference on Road Safety – Time for Results

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- [PHM comment](#)
- [Notes of discussion at EB138](#)

In focus

Prepared at the request of a Member State, the Secretariat report ([EB138/12](#)) provides information on the progress made in attaining the objectives of the [Decade of Action for Road Safety 2011–2020](#) and on the [outcomes](#) of the Second Global High Level Conference on Road Safety: Time for Results, held in Brasília on 18 and 19 November 2015.

There may be some focus on [SDG Goal 3, Target 6](#): “By 2020, halve the number of global deaths and injuries from road traffic accidents”.

Background

[World report on road traffic injury prevention](#), produced in 2004 and co-sponsored by WHO and WB.

More reports [here](#).

PHM comment

The title of this agenda item refers to road safety, not road trauma, and certainly not the burden of disease attributable to personal motorised transportation. The body of the report speaks about road trauma but makes no reference to physical inactivity or air pollution.

A discursive shift has taken place in WHO’s language practices since the 2004 [World report on road traffic injury prevention](#). Since then road safety appears to have moved to centre

stage. This shift from *road trauma* to *road safety* has the effect of excluding transport planning and land use planning from consideration and diverting attention from the wider links between motorisation and the burden of disease, including that associated with physical inactivity and air pollution.

The 2004 [World report on road traffic injury prevention](#) focused on a range of factors which contribute to death and injury on the roads. In a section headed 'factors influencing exposure to risk' it discusses 'motorisation', transport, land use and road planning (p74). Clearly the number of people exposed is a major determinant of the number of people killed or injured.

The discourse shifted significantly after WHO was appointed as coordinator for the [UN Road Safety Collaboration](#) in 2004; the [Decade of Action for Road Safety](#) 2011-2020 was launched; two global ministerial conferences on *road safety* were held: [2009 in Moscow](#), and [2015 in Brasilia](#); and a series of global status reports on *road safety* were produced by WHO in [2009](#) and [2013](#) and [2015](#).

WHO's [Global Status Report on Road Safety 2015](#) is almost entirely about driver and rider behaviour, with short sections on safe vehicles and safe roads but nothing about public transport, urban planning or pollution control.

In many countries the political power of the automobile industry and urban developers has shaped urban planning around roads with the neglect of public and active transport infrastructure.

It appears that the UN and WHO are exposed to similar pressures.

In April 2015 the UN announced that Jean Todt, the president of the Fédération Internationale de L'Automobile (FIA), had been appointed as the [UN Secretary General's Special Envoy on Road Safety](#) ([bio here](#)).

The FIA is the governing body for world motor sport and the federation of the world's motoring organisations, both of which are heavily supported by the automobile industry.

WHO partners with the FIA Foundation in managing the [Road Safety Fund](#) and partners with FIA and the FIA Foundation (and the WB and a group of countries) in the '[Friends of the Decade of Action on Road Safety](#)'.

The UN Road Safety Collaboration, which WHO coordinates, is a typical [global public private partnership](#) with intergovernmental bodies, governments, NGOs and private sector entities. Among the latter are a tyre manufacturer, a steel manufacturer and the international Motorcycle Manufacturers Association, as well as the FIA.

PHM notes (para 9) that United Nations Road Safety Collaboration only attracts around 80 partner organisations to its twice yearly gatherings. In fact there are only 14 Member States participating in the Collaboration and several of these are sub-national.

From a public health point of view there is considerable scope for linking the objectives of cutting greenhouse gas emissions, controlling NCDs and reducing road trauma. However, there are no references to NCDs, greenhouse gas emissions, air pollution or physical exercise in EB138/12 (and only one mention of NCDs in the Brasilia Declaration).

Greenhouse gas emissions, air pollution and physical exercise are all mentioned but only once each in the 2015 global status report.

There are frequent references in both the policy declarations and various reports to the need for an intersectoral approach to road safety. However in this context intersectoral appears to mean the engagement of health with police, auto design standards and road planning. If the slogan of 'One WHO' was being taken more seriously there might be some exploration of the scope for synergies with respect to the advocacy and mobilisation around road trauma, NCDs prevention, air pollution control, greenhouse gas reduction and urban / transport planning.

WHO and the UN are working closely in the field of road trauma / road safety with private sector entities with secondary interests in the policy outcomes. The WHO is producing documents which take a very narrow approach to road trauma policy, neglecting both the urban planning side and the synergies with air pollution and physical activity. The conjunction of these relationships and policy positions raise questions about conflict of interest and improper influence over WHO's activities.

Government investment in urban development and public transport has been under increasing pressure through decades of 'structural adjustment' and 'austerity' (and neoliberalism more generally) which have weakened governments' capacity and willingness to undertake the necessary urban planning and infrastructure development. According to the neoliberal doctrine money transferred from households to auto manufacturers is good but money transferred through taxation to building decent transport and decent cities is somehow wasted.

In this context PHM notes the interest of FIA, and Jean Todt personally, in promoting road investment through their involvement in national 'road assessment programs' and iRAP (the International Road Assessment Program). At the heart of 'road assessment' is a standardised five star rating system, protocols for risk mapping and guidelines for lobbying for public investment in roads. Jean Todt speaking as the Secretary General's Special Envoy celebrated the star rating system as a guest speaker at [EuroRAP meeting in Sept 2015](#) in London ([speech here](#))

The iRAP is also in a partnership with the UN under the [2030 Agenda for Sustainable Development](#). Under the [Agenda](#) there are two SDGs dealing with road trauma and road safety:

- 3.6: By 2020, halve the number of global deaths and injuries from road traffic accidents;
- 11.2: By 2030, provide access to safe, affordable, accessible and sustainable transport systems for all, improving road safety, notably by expanding public transport, with special attention to the needs of those in vulnerable situations, women, children, persons with disabilities and older persons.

The iRAP / SDG partnership appears to have '[generous support](#)' from the World Bank, the FIA Foundation and the Road Safety Fund (jointly managed by WHO and FIA Foundation). It also has funding agreements in place with other development banks. It boasts total funding of USD50m. Safer roads clearly has a place in achieving SDG3.6 although containing motorisation could well be more effective in reducing road trauma as well as addressing global warming. The contribution of iRAP to SDG11.2 would have to be marginal.

PHM is, in principle, in favour of safer roads but there are opportunity costs of investing disproportionately in lobbying for safe roads (and in the road construction which follows from such lobbying). The efficiency question is whether investing comparable resources in lobbying for better urban planning and public transport could deliver a greater yield in terms of burden of disease (including road trauma, physical activity and air pollution) as well as reducing greenhouse gases.

It appears that this is not a question that WHO has asked. Is this because of its close relations with organisations which have secondary interests in the policy outcomes?

This item should provide a useful case study for exploring the application of the emerging FENSA principles, the rules governing WHO partnerships, and risk management in the face of conflict of interest.

7.1 Monitoring of the achievement of the health-related Millennium Development Goals

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In focus

The Secretariat report ([EB138/13](#)) reviews efforts made to achieve the health-related Millennium Development Goals with a focus on global and regional progress, success factors and the unfinished agenda.

Background

See PHM Commentary on [Item 14.1 at WHA68](#).

PHM comment

Thoughtful commentary on levels of achievement of MDG targets and review of the role of WHO strategies, plans and programmes in this achievement.

The review celebrates the achievements of vertical programs as in HIV and malaria but progress in terms of nutrition, health systems and environmental hygiene has been much slower. These are system problems which inhere more deeply in the political and economic structures and which also impose real limits on the potential achievement of the more narrow targets.

This commentary is affected by the recently described 'parallel world fantasy'. (See Scott-Samuel, A. and K. E. Smith (2015). "Fantasy paradigms of health inequalities: Utopian thinking?" *Social Theory & Health*: 1-19.) The parallel world fantasy describes how global policy officials tend to write and speak within a parallel world in which the political economy of global economic crisis and the brutality of imperial geopolitics do not exist and global health policies comprise cost effective interventions, political promises and philanthropic largesse.

7.2 Health in the 2030 Agenda for Sustainable Development

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In focus

The 2030 Agenda for Sustainable Development, adopted by the United Nations General Assembly in September 2015, builds on the Millennium Development Goals but has a much broader agenda for all countries. The Secretariat report ([EB138/14](#)) analyses the implications for health, including the role of the Health Assembly in implementing the 2030 Agenda.

Background

The Secretariat paper provides some useful background. More about the SDGs can be found [here](#).

[UN Resolution A/RES/70/1](#) carries the 2030 Agenda for Sustainable Development, the Declaration and the Goals and Targets.

The Addis Ababa Action Agenda on Financing for Development ([A/RES/69/313](#)) is referenced in the 2030 SD Agenda as the blueprint for mobilising the funds needed to implement the agenda.

Further background and some analytical commentary is to be found in the PHM commentary on: [Item 14.1 on WHA68](#).

PHM comment

The 2030 Agenda for Sustainable Development: the need to go beyond inspiring rhetoric

There is much to appreciate in the [2030 Agenda for Sustainable Development](#). Para 3 illustrates the inspiring rhetoric:

We resolve, between now and 2030, to end poverty and hunger everywhere; to combat inequalities within and among countries; to build peaceful, just and inclusive societies; to protect human rights and promote gender equality and the empowerment of women and girls; and to ensure the lasting protection of the planet and its natural resources. We resolve also to create conditions for sustainable, inclusive and sustained economic growth, shared prosperity and decent work for all, taking into account different levels of national development and capacities.

The 17 goals and 169 targets are comprehensive and visionary; an inspiring vision can mobilise people to work together for change. However, false promises lead to disillusion and withdrawal or worse.

The Agenda promises action on inequality, human rights, gender equity and protection of the planet. There are repeated references to sustainable production and consumption, as in Para 28:

*28. We commit to making fundamental changes in the way that our societies produce and consume goods and services. Governments, international organizations, the business sector and other non-State actors and individuals **must** contribute to changing unsustainable consumption and production patterns ...*

Goal 12 elaborates a series of targets which might contribute to changing unsustainable consumption and production patterns but the Agenda lacks drivers which could **make** *Governments, international organizations, the business sector and other non-State actors and individuals contribute to changing unsustainable consumption and production patterns.*

In fact the Agenda proposes to rely on economic growth (Goal 8), of at least 7% in the LDCs, and free trade (Goal 17, targets 17.10 - 17.12) to fund the necessary transformations.

There are significant contradictions between economic growth and ecological sustainability. [Woodward \(2015\)](#) has estimated that eradicating poverty (using a \$5 per day benchmark) through economic growth would take 200 years and would only be achieved when per capita GDP exceeds \$1m. Woodward points out that carbon constraints are likely to severely limit such 'growth'. Certainly economic growth does not necessarily require greenhouse gas emissions but it is hard to see the projected economic growth as consistent with the control of global warming.

In terms of de-carbonising economic growth the SDGs are very weak. The following from Goals 12(c) illustrates just how weak:

12.c Rationalize inefficient fossil-fuel subsidies that encourage wasteful consumption by removing market distortions, in accordance with national circumstances, including by restructuring taxation and phasing out those harmful subsidies, where they exist, to reflect their environmental impacts, taking fully into account the specific needs and conditions of developing countries and minimizing the possible adverse impacts on their development in a manner that protects the poor and the affected communities

The other targets under Goal 12 are equally weak. Consider for example, 12.6:

Encourage companies, especially large and transnational companies, to adopt sustainable practices and to integrate sustainability information into their reporting cycle.

The promises of the SDGs need to be viewed alongside the drive for plurilateral trade agreements, in particular, the TPP and the TTIP, which run counter in major respects to the promises of the SDGs. A recent report by the [World Bank](#) concludes that the TPP will seriously prejudice the export prospects of Thailand and other countries who are not included in the agreement. In large degree the benefits accruing to Vietnam are achieved at the cost of Thailand through trade diversion.

The Agenda for Sustainable Development does not confront the fact that ceaseless economic growth is embedded in the dynamic of capitalism. When the economy is growing capitalist enterprises are making profits; when capitalist enterprises are making profits the economy is likely to be growing.

The SDGs recognise the need to reduce inequality within and among countries (Goal 10) but the specific targets identified in Goal 10 are extremely weak. If ending poverty (Goal 1) and ending hunger (Goal 2) are not going to be achieved through economic growth it seems even less likely that they will be achieved through wealth transfers.

The SDGs make gestures but do not provide any credible strategy for addressing:

- an unfair trading regime (which sanctions the dumping of subsidised agricultural products driving small farmers off their lands and into huge informal settlements in the cities;
- an unstable financial regime (in which policy priority is given to banks which are too big to fail rather than the communities who suffer as a consequence of greed and lack of effective regulation);
- a global tax regime which drives tax competition and facilitates capital flight and tax avoidance;
- an IP regime which is a major barrier to urgently needed technology transfer;
- an investment regime which privileges the interests of transnational corporations at the cost of reducing the regulatory and policy space of sovereign governments (as in ISDS provisions in contemporary trade agreements).

The contradictions and weaknesses embedded in the SDGs should not take away from the inspiring vision that they project. However, they do underline that the SDGs are not enough; that there remains an urgent need for more fundamental reforms in the structures and flows of the global economy and the power relations which maintain those structures and flows.

Implications the SDGs for WHO

[EB138/14](#) is a thoughtful exploration of the implications for WHO of the emergence of the SDGs. It hints at some of the contradictions embedded in the SDGs, for example:

... only if the governments of developed countries do more to tackle inequality and insecurity at home, as part of their contribution to the Sustainable Development Goals, will they have the political space to pursue the idea of global solidarity that underpins the new Agenda

EB138/14 lists a range of important issues that the Board may wish to discuss under the headings of:

- governance for health,
- progress reporting,
- priority settings,

- finance and resource mobilisation, and
- WHO staff competencies.

Para 49 comments that:

While the new Agenda attaches greater weight to issues such as noncommunicable diseases than was the case in the past, there is no guarantee, given the continued reliance on voluntary funds from official development assistance and development cooperation agencies, that funding to WHO will follow suit.

This may be a reference to the underfunding of NCDs, health systems and action on the SDH as reflected in [Fig 1 of WHA68/6](#) (May 2015).

The Secretariat report is somewhat thin in working through the implications for WHO of the new goals. If WHO is to effectively engage in the intersectoral collaboration suggested by the new goals PHM proposes that an early step would be a fuller review of the implications for health of each of the other SDGs and the flow on implications for WHO priorities and programmes.

In working through the implications for WHO of the SDGs delegates should make a realistic assessment of the drive for change arising from the Agenda.

PHM urges WHO to respond to the SDGs in ways which gain leverage from the inspiring rhetoric but which also raise awareness of the need for more fundamental reforms in the structures and flows of the global economy and the power relations which maintain those structures and flows.

Elements of a resolution

The Secretariat paper is presented for ‘noting’. The report does not suggest a resolution or a decision from the Board. However, the implications of the SDGs for WHO, as set out in this report, could be quite far-reaching and not all member states will support the direction outlined in this paper. There may be a draft resolution or decision in the wings aiming to restrict the scope of WHO’s work in this space.

If a resolution were to be considered PHM would suggest the following core elements:

- PP1: Having considered the report on the implications of the SDGs for health and WHO;
- PP2: recalling [a range of relevant resolutions];
- OP1: **UNDERLINES** the importance for global health of the 2030 Agenda for Sustainable Development, noting in particular:
 - the applicability of the SDGs to all countries; not just those in receipt of development assistance;
 - the breadth of scope and significance of ambition of the goals and mooted targets;
 - the focus on equity and the recognition that tackling inequality and insecurity in the rich world may be a pre-condition for achieving the global solidarity that underpins the new Agenda; and
 - the central importance of health systems to support the role of the health sector in progressing the Agenda;

- OP2: RECOGNISES that realising the vision projected by the SDGs will require a profound transformation of the structures, stocks and flows of the global economy and of the power relations which presently sustain those structures, stocks and flows;
- OP3: RECOGNISES the challenges facing WHO if it is to play its full role in advancing the Agenda, including:
 - the inadequate and inflexible funding provided to WHO on account of the freeze on assessed contributions and the refusal of donors to untie their donations;
 - the barriers to One WHO as a consequence of the competition for visibility and funding of units, departments and clusters;
 - the lack of accountability of member states for implementing resolutions, decisions and guidelines adopted by the Assembly;
 - the lack of accountability of the regional structures of WHO
- OP4: URGES Member States
 - OP4.1: to lift the freeze on assessed contributions;
 - OP4.2: untie their donations to WHO;
- OP5: Requests the Director General:
 - OP5.1: to undertake a review of each of the non-health SDGs to identify issues with significant health implications and to suggest how, in the spirit of intersectoral collaboration and recognising the integrated and indivisible nature of the SDGs, WHO might ensure that the health dimensions are appropriately considered at global, regional and national levels;

7.3 Operational plan to take forward the Global Strategy on Women's, Children's and Adolescents' Health

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In focus

The Secretariat report ([EB138/15](#)) reviews the development of the new Global Strategy on Women's, Children's and Adolescents' Health and highlights the challenges involved in implementation. These include country plans, mobilising funds, commitments, measurement, and accountability.

The Board is invited to provide guidance with respect to next steps. This presumably means that a resolution is being prepared.

The new Global Strategy

The new (updated) [Global Strategy on Women's, Children's and Adolescents' Health](#) was launched by the United Nations Secretary General in September 2015. The new Strategy includes:

- Chapter 4: Vision, Principles, Objectives (Survive, Thrive, Transform) and Targets (drawn from the SDGs which are scheduled to be finalised in March 2016),
- Chapter 5: Nine Action Areas, and
- Chapter 6: Implementation.

Chapter 6 indicates that an Operational Framework is being developed. It speaks of three interconnected pillars which will underpin the delivery of the Global Strategy:

1. Country planning and implementation,
2. Financing for country plans and implementation, and
3. Engagement and alignment of global stakeholders.

The chapter highlights the concrete explicit commitments which are expected of different stakeholder groups.

WHO Operational Plan

The Secretariat report ([EB138/15](#)) outlines the main components of an Operational Plan for WHO to help drive the implementation of the Global Strategy.

The report highlights a series of key activities (para 14) which should be included in country plans. It highlights the need for coordination, refers to the foreshadowed Operational Framework, refers to technical resources, and introduces the Global Financing Facility.

The report underlines the need for concrete commitments (para 18), referring to the list of commitments from page 80 in the Global Strategy, and calls for MS to make specific commitments.

Finally the report reviews the provisions for indicators (drawn from the SDGs) and accountability, in particular the role of the Independent Accountability Panel.

In Annex 2 the Secretariat proposes a set of milestones for the implementation.

It seems likely that there is a resolution being developed, presumably along the lines of the Secretariat's recommendations for country action, specific commitments, coordination, technical support, financing, measurement and accountability.

Background

The Global Strategy for Women's Children's and Adolescents' Health 2016-2030 can be downloaded here: [Every Woman Every Child](#).

The Strategy foreshadows a five year operational framework which will be developed in 2016 and which, presumably, would frame the operational plan foreshadowed in [EB138/15](#).

There is some obscurity about the relationship between the UN process foreshadowed in the Global Strategy for the development of an 'operational framework' in early 2016 and the WHO Secretariat proposal for an 'operational plan'. Presumably the WHO staff are expecting to take the lead in the development of the 'operational framework' and are getting started by asking the EB to mandate this work on an 'operational plan' through the WHO.

PHM comment

The Global Strategy

The Global Strategy has been extensively consulted upon. The principles which are elaborated and which imbue the text will resonate with advocates for women's, children's and adolescents' health in many countries and at all levels. The targets are admirable. The list of evidence based interventions and the descriptions of the enabling environments which will need to be created to enable those interventions to be implemented are useful. The Action Areas identified are also very good.

This is an excellent strategy and needs to be strongly supported. However we highlight some reservations and cautions.

Financing

The Strategy identifies that expanding the funding flows to women's, children's and adolescents' health should draw largely on domestic financing but concludes that there will still be a huge need for development assistance financing in low and some middle income countries.

The World Bank has established a [Global Financing Facility](#) to provide a common platform for bilateral and multilateral donations for women's, children's and adolescents' health in L&MICs. Hopefully the new Global Financing Facility (GFF) will reduce the problem of multiple channels of donor assistance to women's, children's and adolescents' health. However, it is not clear that it will not reproduce the fragmenting impact on health systems of the old vertical funding streams.

The development and stewardship of integrated comprehensive health systems is critical for women's, children's and adolescents' health but there is no guarantee under the GFF that funds which are ear-marked for women's, children's and adolescents' health will not distort health system development in the same ways as the vertical funding of infectious disease programmes has done.

We note the enthusiasm of the World Bank to promote the role of the private sector in reproductive, maternal, newborn, child and adolescent health ([page 19 of Business Plan](#)). This is quite worrying as it appears to be faith based rather than evidence based.

In view of the importance of the country specific 'investment case' in framing disbursements through the GFF we propose that WHO should give priority in its Operational Plan to offering technical assistance to countries in the preparation of their investment cases and in capacity building for this function.

Critical monitoring of the operations of the GFF should also be a key function of WHO's operational plan.

Use of process indicators to follow implementation

There is a sharp focus on targets and indicators in both the Global Strategy and EB138/15 but this is largely restricted to the 17 outcome indicators specified through the SDGs process.

In fact this Strategy is quite innovative in listing, in Annexes 2-4, a series of 'interventions' and a series of 'enabling environments' which are seen as preconditions for delivering those interventions. There are no references in either the Strategy or EB138/15 to the monitoring of progress with respect to interventions and enabling environments.

This must be a major focus on the proposed Operational Plan.

Recognising the macroeconomic determinants of poverty, inequality and undernutrition

There are several references in the Global Strategy to the role of poverty, marginalisation, exclusion and discrimination in contributing to death and disease in this field. However, as is customary in this kind of document there is no reference to the unsustainable and inequitable nature of the global economy which contributes to reproducing poverty, marginalisation and exclusion.

While the rich capitalist countries are rallying around this Strategy and promising contributions to the Global Financing Facility they are at the same time implementing economic policies globally (largely through 'trade' 'agreements') which reproduce the poverty and inequality in the heavy burden countries.

This is a good strategy but one which may be motivated in some degree by the objective of legitimising the prevailing global economic order, through being seen to address the needs of women, children and adolescents.

PHM affirms the importance of addressing the immediate health needs of women, newborns, children and adolescents, including through the interventions and enabling environments mentioned in the Global Strategy. However PHM calls for an approach to global health which also maintains a focus on the macroeconomic and geopolitical dynamics which contribute to reproducing those health needs.

PHM calls for stakeholders in the reproductive, women, newborn, child and adolescent health field to commit to focusing attention on the macroeconomic and geopolitical dynamics which shape health outcomes in this field and to promoting policies which lead towards a more equal, sustainable and inclusive global society.

The operational plan

It seems that the Secretariat is foreshadowing the development of an operational plan which might in due course merge with the operational framework foreshadowed in the Global Strategy.

EB138/15 highlights a number of important issues which should be incorporated into such a Plan.

PHM urges the inclusion amongst such issues:

- priority to providing technical support for the development of the investment cases for countries eligible for and proposing to approach the GFF
- monitoring the priorities approved by the GFF in the funding of investment cases and reporting thereon to the Assembly
- monitoring the impact on health system coordination and coherence of the special purpose funds disbursed through the GFF
- monitoring the implementation of the Global Strategy in terms of the deployment of the interventions listed in the Global Strategy and the enabling environments identified

- to include among the commitments which are urged upon different stakeholder groups continuing attention to the macroeconomic and geopolitical dynamics which shape health outcomes in this field and the need for policies which would lead towards a more equal, just, sustainable and inclusive global society.

7.4 Multisectoral action for a life course approach to healthy ageing: draft global strategy and plan of action on ageing and health

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- [PHM comment](#)
- [Notes of discussion at EB138](#)

In focus

Populations are ageing rapidly, with some of the most significant changes occurring in low- and middle-income countries. As requested in decision [WHA67\(13\)](#) (2014), the draft global strategy and plan of action on ageing and health ([EB138/16](#)) is intended to frame a comprehensive response designed to foster healthy ageing, and one that is relevant to all countries.

[EB138/16](#) outlines the extensive consultation process involved in the development of the draft global strategy and plan of action (GS&PA) and in the appendix presents a summary of the global strategy and plan of action.

The strategy proposes five years of work on evidence building and awareness raising (2015-20) before launching a Decade of Healthy Ageing from 2020 to 2030.

Five strategic objectives are proposed:

- Commitment to action on Healthy Ageing in every country;
- Developing age-friendly environments
- Aligning health systems to the needs of older populations
- Developing systems for providing long-term care (home, communities, institutions)
- Improving measurement, monitoring and research on Healthy Ageing

Activities are proposed under each of these objectives for Member States, the Secretariat (including WHO and other UN bodies), and 'national and international partners'. At the time of writing (late December) the full GS&PA has not been published (notwithstanding the statement to this effect in para 12 of [EB138/16](#)).

The draft global strategy and plan of action (GS&PA) on ageing and health ([EB138/16](#)) should be read in association with the recently released [World Report on Ageing and Health](#).

The development of the World Report (and presumably the draft strategy) was supported by grants from the governments of Japan and the Netherlands and through core voluntary contributions.

Background

The proportion of older people in the population is increasing in almost every country. See Chapter One of the recently released [World Report on Ageing and Health](#). By 2050 most countries will have >30% of their population aged 60+; for many countries well before this.

WHO has been doing good works on Active Ageing for many years; it released the [2002 Active Ageing Policy Framework](#) and the [Madrid Plan of Action](#) was published in 2002 also.

In May 2014 the Assembly considered [A67/23](#) and adopted Decision [WHA67\(13\)](#) which *requested the Director-General to develop, in consultation with Member States and other stakeholders and in coordination with the regional offices, and within existing resources, a comprehensive global strategy and plan of action on ageing and health, for consideration by the Executive Board in January 2016 and by the Sixty-ninth World Health Assembly in May 2016.*

PHM comment

The World Report is a very useful document and the draft GS&PA appears to be also very promising although it is hard to evaluate it solely on the basis of the summary in [EB138/16](#).

The designers of the draft GS&PA are to be particularly commended for the activities proposed to support SOs 3 & 4 which deal with health systems and long term care systems respectively. The corresponding chapters in the World Report are also well presented.

Neglect of the SDGs

It is unfortunate that both the Report and the GS&PA have been prepared without regard to the emerging Sustainable Development Goals. At this same meeting in January the EB will consider a report from the Secretariat which points out that there are health implications in most of the 'non-health' SDGs and argues that WHO should take a pro-active stance in developing intersectoral collaboration around these goals. [Chapter 6](#) of the Report is structured around five domains of functional ability which are essential for older people to:

- meet their basic needs;
- learn, grow and make decisions;
- be mobile;
- build and maintain relationships;
- contribute.

The social and economic norms which facilitate or obstruct these abilities are determined across many of the 'non-health' [SDGs](#). However, under the relevant strategic objective in the draft GS&PA ([SO2](#) Developing age-friendly environments) there is no consideration of how intersectoral collaboration across the SDGs might provide leverage to support these abilities.

(Despite the lack of any reference to the SDGs in the World Report, its Chapter Six provides a more coherent account of these five abilities than SO2.)

SO2 does refer (very briefly) to poverty, housing, community spaces etc but the 'ability' to *contribute* appears to have been omitted entirely.

The brutality of neoliberal transnational capitalism

It would be too much to expect the WHO to comment on the degree to which the barriers to healthy ageing are embedded in the norms of neoliberal globalising capitalism and its cultivation of inequality and insecurity; its continuing pressure on public revenues (through 'tax competition'); and its disregard for full employment, decent work and adequate pensions as part of equitable social protection.

Para 16 of [EB138/14](#) is directly relevant to creating the conditions for healthy ageing:

... only if the governments of developed countries do more to tackle inequality and insecurity at home, as part of their contribution to the Sustainable Development Goals, will they have the political space to pursue the idea of global solidarity that underpins the new Agenda.

The closest that the World Report comes to these links is in its discussion of the 'economic imperative' [from page 16](#). These relationships are completely absent from the draft GS&PA.

The false promises of the UHC rhetoric

Strategic objectives 3 & 4 deal with health care and long-term care respectively. Financial provision for these is reduced to single slogans in the summary of the GS&PA but the discussions of institutional relations and financing arrangements in the corresponding chapters of the World Report are more insightful; see [page 113](#) and [page 144](#).

In order to preserve its collaboration with the World Bank under the flag of "UHC" WHO has backpedalled in terms of providing guidance regarding institutional configurations for decent health care. However chapters 4 & 5 of the World Report include useful discussions of the kinds of service systems required for decent health care and long-term care for older folk. These service relationships and patterns of service delivery are not compatible with the privatized marketized stratified health care systems advocated by the World Bank under the shared rubric of UHC.

Neglect of the PHC model

The PHC model envisages PHC agencies and practitioners working with their communities to identify and address the barriers to better health and better health care, including healthy ageing. This model recognises the need for good policy models *and* for a constituency which will push for such models to be introduced. By contrast the current discourse of patient centred care refers to the models of care but fails to consider the constituency-building challenge.

This applies to both health systems development, the development of long-term care, and to the social determinants of healthy ageing, including social protection.

Core elements of a resolution on Healthy Ageing

The EB is expected to adopt a draft resolution for the consideration of WHA69. The Secretariat's preferred position would be simply an endorsement of the draft GS&PA as presented in EB138/16.

Some member states will see it as their task to restrict further engagement of WHO in intersectoral collaboration (linked or otherwise to the SDGs) or further exploration of institutional arrangements for social protection, health care and long-term care. Certainly not if they are couched in human rights terms.

PHM urges member states to ensure that any resolution or decision arising out of this item includes support for the following provisions:

- explicit recognition that the system relationships and standards of performance implied in Objectives 3 & 4 and described in chapters 4 & 5 of the Report require single payer funding and strong publicly accountable stewardship and are not compatible with private marketised funds mobilisation and competitive private sector markets in the delivery of services;
- stronger endorsement of the Comprehensive PHC model including active partnerships between PHC agencies and practitioners and the communities they are serving directed to achieving action in service development and action around the social determinants of healthy ageing;
- stronger appreciation of the strategic benefits of linking Objective 2 (Developing age-friendly environments) more explicitly to the range of relevant non-health SDGs and action to address the social determinants of health;
- call for lifting of the freeze and untying of donations to WHO so that the priorities adopted in WHO's governing bodies can be pursued by the Secretariat without depending on the largesse or otherwise of particular donors.

7.5 Health and the environment: draft roadmap for an enhanced global response to the adverse health effects of air pollution

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- [Notes of discussion at EB138](#)

In focus

“Air pollution is a major preventable cause of disease, accounting for 7 million deaths a year. The report ([EB138/17](#)) will provide information to the Executive Board in response to resolution [WHA68.8](#) (2015) – the first resolution on air pollution and health – which requested the Director-General to propose to the Sixty-ninth World Health Assembly a roadmap for an enhanced global response to the adverse health effects of air pollution and to report on progress made and challenges faced in mitigating these effects.”

Background

This issue has been fiercely contested in recent governing body meetings. However the issues at stake have not been articulated very clearly.

From EB136 Annotated Agenda: A report on addressing the health impact of air pollution ([EB135/4](#)) was considered by the Executive Board at its 135th session. In light of comments made during the discussions, the Board decided to include the issue of the health impact of air pollution on the provisional agenda of its 136th session. Among other things, the [revised] report ([EB136/15](#)) outlines a number of strategies for the prevention, control and mitigation of the adverse effects of air pollution on health.

See PHM comments in advance of the discussion at EB135 [here](#). These issues remain of concern.

The discussion of air pollution was sharply contested at EB136 in Jan 2015. See PSRs of

1. 8th meeting ([here](#)) draft resolution presented; discussion deferred because informal consultations underway;
2. 15th meeting ([here](#)) revised resolution tabled; consensus not achieved; Decision [EB136\(14\)](#) adopted:

The Executive Board, having considered the report on addressing the health impact of air pollution [[EB136/15](#)], noted the ongoing discussions on the draft resolution under agenda item 7.2, contained in document [EB136/CONF./9 Rev.1](#), and encouraged Member States to finalize this work, in order for the draft resolution to be duly considered by the Sixty-eighth World Health Assembly. (Fifteenth meeting, 3 February 2015)

The discussion continued at WHA68. Again sharply contested. See PSRs of:

1. 6th meeting (page 2, [here](#)) highly contested [lots of square brackets] draft resolution tabled; formal discussion deferred because informal consultations underway;
2. 14th meeting (from page 2, [here](#)) considered new draft resolution, broad support;
3. 15th meeting (from page 2, [here](#)) and [WHA68.8](#) adopted.

WHA68 (2015) adopted resolution [WHA68.8](#) which, inter alia, requests the Director-General to propose to the Sixty-ninth World Health Assembly a roadmap for an enhanced global response to the adverse health effects of air pollution. This is the focus of [EB138/17](#) but what are the other issues which are in contest?

A preliminary analysis of the text of the unfinished draft resolution from EB136 ([EB136/CONF./9 Rev.1](#)) compared with the draft tabled at the 6th meeting of Cttee A at WHA68 ([PSR6](#)), the first revision tabled at the 14th meeting ([PSR14](#)), and the final adopted version ([WHA68.8](#)) identifies some of the key issues which were contentious. These include naming diesel and coal (opposed by Saudi Arabia); linking control of air pollution to the control of greenhouse gas emissions (opposed by Saudi Arabia); exploration of the use of TRIPS flexibilities in deploying new technologies in developing countries (proposed by India and Egypt; opposed by USA, EU, Norway Switzerland and Monaco); and various references to technology transfer and the funding of technology transfer. China, sometimes with the USA, proposed including 'on a voluntary basis' in many of the operative paragraphs.

The proposed Blueprint ([EB138/17](#)) seeks to address the fundamental issues associated with air pollution, building on the extensive expertise and previous work undertaken by and through WHO, but in a way which carefully steers a safe path through the member state sensitivities revealed in the debates leading to [WHA68.8](#).

PHM comment

PHM congratulates the Secretariat on the very constructive Blueprint ([EB138/17](#)). However, the Blueprint has, of necessity, skirted around some of the more issues which were contentious in the earlier governing body debates, in particular, regarding the ground rules for intersectoral collaboration. Both [WHA68.8](#) and the Blueprint are quite ambivalent about the role of the health sector in addressing the problem of air pollution holistically, with repeated references focused on 'health effects' relatively narrowly, and more diffuse references to 'intersectoral engagement'.

Member states must recognise that:

- Ambient air pollution is closely associated with greenhouse gas emissions from fossil fuel powered industries, in particular, power generation and motorised transport;

- In the large informal settlements of the megacities of the developing world, ambient air pollution and indoor air pollution reflect the lack of clean, efficient and affordable energy supplies;
- A focus on small scale clean energy technologies for domestic cooking, in homes without access to electricity, should not detract from the urgency of efficient and affordable energy infrastructure in both urban and rural settings;
- Technical innovation and the introduction of clean technologies, in power generation and transport, call for massive investment and reframed policy environments (regulation, incentives, subsidies, etc);
- In the present regime of neoliberal economic globalisation, transnational corporations with global reach control in large degree the flow of funds to R&D and productive enterprise; the global policy environment which shapes such investment flows is a major determinant of action on clean energy;
- Fossil fuel corporations (and their shareholders and the politicians who represent them) have actively sought to prevent investment in clean energy and clean transport and to prevent the reform of policy environments (which shape investment);
- Low standard / high protection patent regimes, linked with tight investor protection provisions, both of which are being aggressively driven through plurilateral economic integration agreements, constitute together a major barrier to the governments of poorer countries deploying advanced clean energy and transport technologies;
- Access, by governments of poor countries, to advanced clean energy technologies can be facilitated by international funds mobilisation ('multi-stakeholder partnerships') or by lowering the IP barriers; the latter is more sustainable and less exposed to distortion by vested interests.

The Blueprint provides scope for addressing many of the above fundamentals although in very general terms. In view of WHO's total dependency on donors for programme funding it is not surprising that the sensitivities revealed in the governing body debates have shaped the Blueprint.

PHM urges member states to insist on a more strategic and more focused approach to the fundamental determinants of air pollution. This should include:

- Collaboration with UNCTAD to define the policy environments shaping investment in clean energy and transport and recommend how these might be reformed; such collaboration should include case studies of particular industries, corporations and countries;
- Collaboration with WIPO and WTO to define the ways in which economic integration agreements (in particular IP and ISDS provisions) shape the access to clean energy technologies of developing country governments and what provisions in such agreements would be required to overcome such barriers;
- Partnerships with civil society organisations, such as Corporate Accountability International, in exposing the role of disinformation, corruption and intimidation in the defensive strategies of the fossil fuel industry.

7.6 Role of the health sector in the sound management of chemicals

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In focus

“At the request of Member States, the Secretariat will provide information on the importance of sound management of chemicals for the protection of human health, and on the role of the health sector in chemicals management. The results of a Secretariat consultation to identify priorities for action by the health sector will also be presented. The Board is invited to note the report.”

It appears that document EB138/18 (not published as of late November) will incorporate much of the material already reported on the WHO website: (i) reporting on the consultation [here](#) and (ii) listing the updated health sector priorities [here](#).

Background

A number of WHA resolutions dealing with various aspects of chemicals safety have been adopted ([here](#)).

The most recent discussion in the Assembly was in 2014 at WHA67 in relation to the finalisation of the Minamata Convention regarding mercury exposure.

- Documents: [A67/24](#) and resolution [EB134.R5](#),
- Debate: [Item 14.5 commenced](#) (11th meeting); [Item 14.5 finalised](#) (12th meeting);
- Resolution [A67.11](#)

Secretariat document [A67/24](#) dealt mainly with mercury but in paras 18-22 it canvassed the wider issues associated with chemicals safety.

18. Mercury is only one of a number of chemicals of major public health concern. Preventable exposure to lead, carcinogens, highly hazardous pesticides and other hazardous chemicals continues to occur. These exposures result in significant disease burden and demands on health systems. In the outcome document of the United Nations Conference on Sustainable Development (Rio de Janeiro, Brazil, 20–22 June 2012) “The future we want”, deep concern was expressed that many countries lack the capacity for sound management of chemicals, and called for additional efforts to enhance work towards strengthening capacities, including

through partnerships, technical assistance and improved governance structures. Governments reaffirmed their 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.

19. Member States have numerous opportunities to reduce or eliminate exposures to hazardous chemicals, including implementation of the [Strategic Approach to International Chemicals Management](#). In resolution [WHA59.15](#) on that matter, the Health Assembly urged Member States to take full account of the health aspects of chemical safety in national implementation of the Strategic Approach and to participate in national, regional and international efforts to that end, including the [International Conference on Chemicals Management](#). The strategy for strengthening the engagement of the health sector in the implementation of the strategic approach, adopted by the International Conference on Chemicals Management at its third session (Nairobi, 17–21 September 2012), sets out [various actions](#).

20. Member States are invited to participate in [WHO's Chemical Risk Assessment Network](#), which was established on 1 July 2013 in recognition of the need for enhanced global efforts to share expertise on assessing and managing the risks associated with exposure to hazardous chemicals. Its main objectives are to provide a forum for scientific and technical exchange, facilitate and contribute to capacity building, and assist in the identification of emerging risks to human health from chemicals.

21. In 2002 the World Summit on Sustainable Development decided to phase-out lead paints. The [Global Alliance to Eliminate Lead Paint](#) is an initiative jointly undertaken by UNEP and WHO following a resolution of the second International Conference on Chemicals Management. The WHO Secretariat endorses the encouragement of the third International Conference to all governments, civil society organizations and the private sector to contribute to achievement of [the goal of the Global Alliance](#).

22. In order to guide the work of the Secretariat and Member States towards the achievement of the 2020 goal for the sound management of chemicals, the Secretariat proposes to consult Member States on identifying a set of core priority actions for the health sector.

Para 18 (above) refers to the Outcomes Document from the 2012 UN Conference on Sustainable Development. Subsequently the 2030 Agenda for Sustainable Development has been adopted including its 17 goals and 169 targets ([here](#)). There are several references to chemicals safety:

- *Para 34 of the Agenda: "We will reduce the negative impacts of urban activities and of chemicals which are hazardous for human health and the environment, including through the environmentally sound management and safe use of chemicals, the reduction and recycling of waste and more efficient use of water and energy";*
- *Target 3.9: "By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination;*

- *Target 6.3: “By 2030, improve water quality by reducing pollution, eliminating dumping and minimizing release of hazardous chemicals and materials, halving the proportion of untreated wastewater and substantially increasing recycling and safe reuse globally”;*
- *Target 12.4: “By 2020, achieve the environmentally sound management of chemicals and all wastes throughout their life cycle, in accordance with agreed international frameworks, and significantly reduce their release to air, water and soil in order to minimize their adverse impacts on human health and the environment”.*

In para 22 (above) of [A67/24](#) the Secretariat indicates that it intends to consult Member States on identifying a set of core priority actions for the health sector. This consultation is reported [here](#) and the updated health sector priorities are listed [here](#). In summary these are:

- Devising better and standardized methods to determine impacts of chemicals on health;
- Formulating strategies aimed at prevention of ill-health and disease caused throughout the life course by chemicals;
- Building capabilities of countries to deal with poisonings and chemical incidents and emergencies;
- Promoting alternatives to highly toxic and persistent chemicals;
- Filling of gaps in scientific knowledge;
- Elaborating globally harmonized methods for chemical risk assessment; and
- Actions to improve ability to access, interpret and apply scientific knowledge.

The IPCS web site also includes a list of [10 chemicals of public health concern](#) including [Air pollution](#), [Arsenic](#), [Asbestos](#), [Benzene](#), [Cadmium](#), [Dioxin and dioxin-like substances](#), [Inadequate or excess fluoride](#), [Lead](#), [Mercury](#), and [Highly hazardous pesticides](#).

Further information is available through WHO’s ‘concise international chemical assessment documents (CICADs)’ [here](#).

For burden of disease estimates see Prüss-Ustün, Annette, Carolyn Vickers, Pascal Haefliger, and Roberto Bertollini. "Knowns and Unknowns on Burden of Disease Due to Chemicals: A Systematic Review." *Environmental Health* 10, no. 9 (2011). <http://dx.doi.org/10.1186/1476-069X-10-9>.

8.1A Implementation of the International Health Regulations (2005)

See also [PHM Commentary on 8.1B: Report of the First Meeting of the Review Committee on the Role of the IHRs in the Ebola Outbreak and Response](#)

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In focus

[EB138/20](#) reports on the implementation of the IHRs and on the international response in 2015 to public health events and emergencies.

It also reports on progress with respect to monitoring core capacity and a [concept note](#) being developed for WHA69. The concept note indicates that the approval of the EB138 will be sought in Jan 2016.

EB138/20 also reports on two initiatives regarding capacity building in relation to the IHR core capacities, one involving the World Bank and the other the G7.

Background

Lots of background references are available from the WHO [IHR \(topics\) page](#)

PHM comment

Many member states have not established in full the core capacities required of all member states by the IHRs.

The self-assessment method for monitoring capacity development is inadequate. The WHO Secretariat is developing a revised approach to monitoring and assessment including an external evaluation component ([concept note here](#)). A formal proposal will be submitted to WHA69 in May 2016. The EB will be asked to approve the updated version.

The tone of the commentary on IHR core capacities maybe moving from finger pointing to financial and technical assistance for those L&MICs who need help.

8.1B Report of the First Meeting of the Review Committee on the Role of the International Health Regulations (2005) in the Ebola Outbreak and Response

See also [PHM Commentary on 8.1A: Implementation of the IHRs](#)

Contents

- [In focus](#)
- [Background](#)
- [PHM comment](#)
- [Notes of discussion at EB138](#)

In focus

[EB138/20](#) conveys to the Executive Board a progress report on the work of the Review Committee on the Functioning of the International Health Regulations (2005) in the Ebola Outbreak and Response including the report of the first meeting of the Review Committee in August 2015.

An updated version following further discussions since August will be reported to the Board, certainly in the oral presentation by the Chair of the Committee and perhaps as a revised version of EB138/20.

The final report of the Review Committee will be submitted to WHA69 in May.

Background

Review Committee on the Role of the IHRs in Ebola Outbreak and Response: [home page](#).

See also the [final report of the Ebola Interim Assessment Panel](#) (and presentation to the Review Committee by the erstwhile chair of the Interim Assessment Panel at Appendix 3).

PHM comment

The listing of 13 themes which are reported from the Review Committee's discussions (Para15) is very useful.

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

Contents

- [In focus](#)
- [Background](#)
- [PHM comment](#)
- [Notes of discussion at EB138](#)

In focus

The Director-General will transmit two reports for the consideration of the Executive Board:

- [EB138/21](#), a biennial report on the status of, and progress in implementing, the [Pandemic Influenza Preparedness Framework](#) in line with the relevant obligations under [section 7.4.1](#) of the Framework:
 - in Para 11 the Secretariat comments that the [Global Action Plan for Influenza Vaccines](#) terminates in 2016 and that the Review of the Framework might recommend that some activities from the Global Action Plan continue under the PIP Framework;
 - Paras 21-23 report on work under way regarding how the PIP Framework should be operationalised in relation to genetic sequence data; this was also discussed at the AG meeting ([more here](#)); there may be more comment on this issue at the EB;
 - Para 15 comments on challenges facing the development of [standard material transfer agreements](#) with manufacturers; there may be some comment by EB members on the issues raised in this para;
- [EB138/21 Add.1](#) reports on the outcomes of the Special Session of the Pandemic Influenza Preparedness Framework [Advisory Group](#), which was held in Geneva on 13 and 14 October 2015 to discuss the [review of the Framework and its annexes](#).
 - Paras 5-8 summarise the issues raised by industry representatives and other stakeholders during the consultation stage of the Advisory Group meeting;
 - Paras 14-19 set out the recommendations of the Advisory Group to the DG regarding the scope and terms of reference of the Review of the Framework.

Background

See [WHO PIP Page](#)

See [Background Notes](#) in PHM's Commentary on Item 16.2 at WHA67 on PIP

PHM comment

The focus of the EB in this item will be procedural, in particular regarding Review.

We note that there is no reference, in either document prepared for this discussion, to the (strict or less strict) application of the definition under PIP of biological materials and whether the strict application might lead to the exclusion of significant animal viruses. This was discussed at EB134 and WHA67 (see [here](#)).

8.3 Smallpox eradication: destruction of variola virus stocks

Contents

- [In focus](#)
- [Background](#)
- [PHM comment](#)
- [Notes of discussion at EB138](#)

In focus

The EB will consider the report of the [Independent Advisory Group on Public Health Implications of Synthetic Biology Technology Related to Smallpox](#).

As reported in [EB138/22](#), the Advisory Group concluded “that the risk of the re-emergence of smallpox has changed and that there is a need to update preparedness efforts and to adapt research frameworks”.

This will be quite controversial as there is a widely held view, including among many experts, that the remaining stocks should be destroyed.

It maybe that the issue will be deferred to EB139 in May 2016 since the advice of the WHO Advisory Committee on Variola Virus Research (ACVVR) might not be available for EB138.

Background

The proposed destruction of remaining variola virus stocks is a recurring item on the WHA agenda. For a summary of this history see PHM comment prepared for WHA67 [here](#).

This item was considered at EB134, informed by [EB134/34](#) (Jan 2014) and again at WHA67 (May 2014), informed by [A67/37](#) (a revision of [EB134/34](#) following the debate within the Board). The focus of discussion was again whether to set a timetable for the destruction of remaining variola stocks. [A67/37](#) provides a summary of previous discussions and decisions regarding the variola stockpile.

There was some concern expressed at the Board in Jan 2014 (EB134) regarding modern biosynthetic technologies and the possibility of synthesising the virus from the known genome sequence and the DG indicated that she proposed to convene an expert group to advise on this possibility. See official record of discussion at WHA67: [WHA67/2014/REC/3](#).

The Secretariat report ([EB138/22](#)) reports on the convening of a Scientific Working Group ([report here](#)) and an Independent Advisory Group on Public Health Implications of Synthetic Biology Technology Related to Smallpox ([report here](#)); summarises the recommendations of the IAG; describes the process of conducting the WHO’s biosafety inspections of the two

variola virus repositories; summarizes the work being carried out on the operational framework for access to WHO's smallpox vaccine stockpile; and provides information on the WHO Advisory Committee on Variola Virus Research.

EB138/22 advises that the Independent Advisory Group "concluded that the risk of the re-emergence of smallpox has changed and that there is a need to update preparedness efforts and to adapt research frameworks" (report [here](#)).

The key conclusions and observations of the IAG include:

1. the risk of smallpox re-emergence has increased with the low cost and widespread availability of technology to synthesize genomes;
2. the WHO recommendations concerning synthesis and use of variola virus DNA fragments should be revised urgently (see page 12 for more detail);
3. MS should amend national public health laws so as to provide legal backing for WHO's recommendations concerning the distribution, handling and synthesis of variola virus DNA;
4. if the last stocks of the variola virus had been destroyed in 1996 as originally mandated the risk of synthesis would not arise because the virus had not been sequenced at that time;
5. if there is a refusal to destroy the variola virus, it is unlikely that any dangerous pathogens would be destroyed following eradication in the future;
6. in the event of an outbreak in a remote location "it would be beneficial to have a reference standard against which to measure a circulating virus" to reduce the risk associated with a delay in diagnosis; (see discussion page 9); and
7. consideration should be given to expanding the number of research sites and developing further expertise at the global level (no consensus on these two issues).

EB138/22 advises that WHO biosafety inspection teams visited and inspected the containment facilities at the two WHO collaborating centres (Koltsovo, Novosibirsk Region, Russian Federation) and the Centers for Disease Control and Prevention (Atlanta, Georgia, United States of America), in December 2014 and May 2015 respectively. The reports of these biosafety inspections are under preparation, currently pending the submission of self-assessment reports and supplementary information by the repositories to WHO. Once finalized, they will be submitted to the Secretariat to be made available on the WHO website prior to the Sixty-ninth World Health Assembly.

EB138/22 advises that the WHO Advisory Committee on Variola Virus Research will meet in Geneva in early January 2016, before the EB but the report of this meeting might not be ready for the EB.

PHM comment

The reports of the SWG and the IAG are useful.

It is apparent that the risk of smallpox re-emergence has increased with the low cost and widespread availability of technology to synthesize genomes. (It is ironic that if the last stocks of the variola virus had been destroyed in 1996 as originally mandated the risk of synthesis would not arise because the virus had not been sequenced at that time.)

The recommendations regarding the revision of the guidelines under the IHRs appear

sensible as does the enforcement of these guidelines through national public health laws.

It appears that there was a view in the IAG to the effect that destruction of remaining stocks could lead to a delay in diagnosis in the event of an outbreak in a remote area. One corollary of this view was that the number of research sites (with variola stocks) should be expanded so that reference materials for confirmation of the diagnosis could be made available more rapidly. This position appears to argue for increasing the risk (more sites) in order to decrease the risk (more rapid diagnosis).

PHM's position has been that WHO should proceed to the final destruction of the remaining stocks of variola virus. The only argument for not proceeding turns on the need for reference material for more rapid diagnosis. This argument needs to be tested more robustly in both technical and policy terms.

8.4 WHO response in severe, large-scale emergencies

Contents

- [In focus](#)
- [Background](#)
- [PHM comment](#)
- [Notes of discussion at EB138](#)

In focus

In line with resolution EBSS3.R1 (2015), the Secretariat report ([EB138/23](#), published very late) provides an overview of the progress made by the Organization in responding to Grade 3 emergencies during 2015. It describes the scope and scale of all emergencies to which WHO has responded during the year, and includes a summary of WHO's activities in each of the six Grade 3 emergencies (namely, those in Central African Republic, Iraq, Nepal, South Sudan and Syrian Arab Republic, together with the Ebola virus disease outbreak in West Africa).

Background

[Panel suggests separate WHO subgroup for outbreaks](#)

See also:

- Nov 15 Review committee [initial report on WHO outbreak and emergency response reforms](#)
- Nov 19 AP [story](#)
- Jul 31 CIDRAP News story: [WHO Ebola-related emergency response reforms advance](#)
- Background on [Harvard-LSHTM review on global Ebola response](#)

8.5 Global action plan on antimicrobial resistance

Contents

- [In focus](#)
- [Background](#)
- [PHM comment](#)
- [Notes of discussion at EB138](#)

In focus

The Board will consider [EB138/24](#) which, in line with resolution [WHA68.7](#) (May 2015), reports on discussions with the UN regarding options for a high-level meeting on ABR in 2016, on the margins of the United Nations General Assembly.

Background

The increasing prevalence of antimicrobial resistance (combined with the slowdown in the development of new antimicrobials) has been recognised as a major threat within public health for some years.

In 2001 WHO published the [global strategy for containment of antimicrobial resistance](#), and the Health Assembly has adopted several resolutions on the subject including [WHA60.16](#) concerning the rational use of medicine and [WHA62.15](#) on prevention and control of multidrug-resistant tuberculosis and extensively drug-resistant tuberculosis and [WHA67.25](#) (in May 2014). Various initiatives have been launched, including in 2011 a call for action on [World Health Day](#), with a policy package for stakeholders. In May 2014 WHO released the [report of the global surveillance of antimicrobial resistance](#).

WHA68 (May 2015) considered [A68/19](#) which provided a summary report on progress made in implementing resolution [WHA67.25](#) on antimicrobial resistance.

One of the commitments in [WHA67.25](#) was to produce a global action plan on antimicrobial resistance. A draft global action plan was considered by WHA68 ([A68/20](#)) and after a long debate was adopted ([WHA68.7](#)). Through this resolution the Assembly adopted the Global Action Plan (GAP); urged MSs to implement the Plan, including developing national action plans; and requested the DG to undertake a range of actions. (See [PHM Comment](#) from May 2015 on the provisions of the GAP.)

Among the range of actions requested of the DG was “to elaborate, in consultation with the United Nations Secretary-General, options for the conduct of a high-level meeting in 2016, on the margins of the United Nations General Assembly, including potential deliverables, and to report to the Sixty-ninth World Health Assembly through the 138th Executive Board”.

This is the focus of Secretariat document [EB138/24](#) which reports that discussions are in progress.

PHM comment

There is nothing of substance in EB138/24. PHM looks forward to WHA69 for the more substantive reports on the implementation of the GAP.

8.6 Polio

Contents

- [In focus](#)
- [Background](#)
- [PHM comment](#)
- [Notes of discussion at EB138](#)

In focus

In 2015, wild poliovirus transmission is at its lowest level in history. Resolution [WHA68.3](#) (May 2015) recognized that progress has been made and urged Member States to fully implement and finance the [Polio Eradication and Endgame Strategic Plan 2013–2018](#).

The report before the Executive Board in Jan 2016 ([EB138/25](#)) summarizes the impact of national emergency action plans in the remaining countries affected and of the temporary recommendations under the [International Health Regulations \(2005\)](#) in connection with the public health emergency of international concern. (See [WHO Statement](#) for the original statement declaring the emergency.)

The report also confirms April 2016 as the date for the globally coordinated switch from the trivalent formulation of oral polio vaccine to the bivalent formulation (see SAGE discussion from p6 of [WER 89\(01\)](#)), and outlines a revised timeline for global certification of poliomyelitis eradication and associated budget implications.

The Board is invited to note the report and to urge Member States to ensure full implementation of resolution WHA68.3.

Background

This report traverses a range of somewhat different issues:

- the interruption of wild poliovirus transmission
 - wild poliovirus type 2 declared eradicated globally;
 - Afghanistan and Pakistan only remaining endemic countries with falling incidence of new cases of wild type polio; Nigeria no longer recognised as endemic;
 - international spread of wild virus continues (from both Afghanistan and Pakistan);
- circulating vaccine-derived type 1 (Madagascar & Lao) and type 2 (Nigeria, South Sudan);
 - importance of stopping outbreaks of circulating vaccine derived poliovirus type 2 (cVDPV2) before removal of type 2 from oral PV;
 - vaccine derived polio reflects low level of immunisation coverage;

- withdrawal of type 2 component of oral PV;
 - transfer to bivalent oral vaccine scheduled for late April 2016;
 - priority to ensuring inactivated vaccine available before switch, especially in high risk countries;
 - stockpiles of inactivated and oral type 2 vaccines in case of outbreaks of VD polio 2;
- need to strengthen routine immunisation;
- containment of PV2
 - need inventory of facilities where PV2 (wild and Sabin) is held;
 - destruction of PV2 materials (wild and Sabin)
 - biorisk provisions where holding PV2 is regarded as 'essential';
- legacy planning; WHO guidelines but national leadership critical;
- funding shortfall (of \$2 b) owing to delay in estimated date of achieving interruption of wild PV transmission.

Some of these issues are quite technical. [WER 89\(01\)](#) is a useful resource. Further information can be found under [topics](#) and [GPEI](#).

PHM comment

Polio is a disease of war, displacement, poverty and fragile health systems. These are the essential conditions which have so far prevented eradication.

The work of WHO and its partners and the field staff in polio eradication is admirable but it would be good if the experience of WHO in polio could find a place in the continuing development of the SDGs, in particular the non-health goals such as:

- 1. No poverty
- 6. Clean water and sanitation
- 10. Reduced inequalities
- 16. Peace, justice and strong institutions.

The polio experience also underlines the importance of strong health systems structured around the PHC model and with strong district health system structures. A clear and valued role for CHWs is crucial in this.

8.7 Promoting the health of migrants

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- [In focus](#)
- [Background](#)
- [PHM comment](#)
- [Notes of discussion at EB138](#)

In focus

The current global refugee and migrant crisis underlines the need to have a coordinated and strategic response to the public health and health-system implications of large-scale population movements, and the right to health care of the populations concerned. In response to a request by Member States, the Secretariat will submit a report ([EB138/26](#)) that provides an update on implementation of resolution [WHA61.17](#) (2008) on the same subject and information on key public health issues facing refugees and migrants; and that considers the way forward with regard to strengthening the capacity of Member States' health systems to provide refugees and migrants with the essential and necessary health support at the initial stages of population movements and thereafter.

Useful links

[International Organisation for Migration](#)

[UN High Commission for Refugees](#)

[Special Rapporteur on the Human Rights of Migrants](#)

[Human rights of migrants \(August 2014\)](#). Report of Special Rapporteur on the Human Rights of Migrants (to UNGA)

[SDGs](#)

PHM comment

The Secretariat report ([EB138/26](#)) provides a useful overview of current migration and refugee trends and some of the health problems migrants and refugees face. It lists some of the actions undertaken by the Secretariat as mandated through [WHA61.17](#) (2008). (It is noteworthy that this review does not make any reference to actions undertaken through WPRO, certainly not because there are no problems in this region). The report concludes by articulating eight priorities for member states, partners and 'other stakeholders'.

However, the report is weak in relation to human rights and the challenges of intersectoral collaboration in this space and is mute in relation to the social and political determination of

health in relation to migration, displacement and refugees. All three principles are identified as cross cutting priorities in WHO's GPW 2014-19 and the importance of human rights to health is enshrined in the WHO Constitution (see [Box 1 of GPW14-19](#)).

Action on the social determination of health is recognised in the ([GPW14-19](#)) as a cross cutting priority:

The concept of social determinants of health constitutes an approach and a way of thinking about health that requires explicit recognition of the wide range of social, economic and other determinants associated with ill health, as well as with inequitable health outcomes. Its purpose is to improve health outcomes and increase healthy life expectancy. The wider application of this approach – in line with the title of the Twelfth General Programme of Work and in a range of different domains across the whole of WHO – is therefore a leadership priority for the next six years in its own right.

Implicit in the concept of the social determinants approach to health, as articulated in the Rio Political Declaration, is the need for better governance of health, both within national governments, and in relation to the growing number of actors in the health sector. This is generally referred to as health governance. Equally, the social determinants approach promotes governance in other sectors in ways that positively impact on human health, referred to as governance for health. This latter perspective is well illustrated by the whole-of-society approach to noncommunicable diseases, as well as in a statement made in 2010 by the foreign ministers of the seven participating countries in the Foreign Policy and Global Health Initiative: "Foreign policy areas such as security and peace building, humanitarian response, social and economic development, human rights and trade have a strong bearing on health outcomes".

Against this background [EB138/26](#) is lacking any useful discussion of:

- the inhumane treatment of refugees (see for example the repeated findings by the Human Rights Council that Australia's treatment of refugees constitutes a violation of international law);
- the role of economic insecurity, promoted by neoliberal economic policies, in driving racism and xenophobia;
- the role of imperialism (through war, sanctions and political support for brutal and oppressive regimes) in mass displacements;
- the increasing role of climate change in driving population movements with related health consequences;
- the role of agricultural dumping in creating food insecurity and urbanisation (internal displacement);
- a global economy which treats over a billion people as surplus to requirements other than as a reserve army to threaten those who do have jobs with lower wage competition.

These factors all lie outside the technical domain of disease causation, prevention and treatment. However, the GPW14-19 was subtitled 'Not merely the absence of disease' recognising that WHO has a responsibility to contribute to 'whole-of-society' approaches to the problems of migrants and refugees.

A useful first step would be to approach those intergovernmental organisations whose mandate is more centred on these issues with proposals for cooperation, for example, in terms of meetings or status reports. Clearly several of the SDGs speak directly to these issues.

9.1A Update on 2014 Ebola outbreak and Secretariat response to issues raised

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- [PHM comment](#)
- [Notes of discussion at EB138](#)

In focus

In response to the relevant requests in decision [WHA68\(10\)](#) (2015), the Secretariat report ([EB138/27](#), very late) reviews the status of WHO's work on developing a new programme for outbreaks and emergencies with health and humanitarian consequences, as catalysed by recent crises, including the Ebola virus disease outbreak in West Africa.

The report describes progress made in improving WHO's ability to maintain organizational readiness; to respond in a predictable, capable, dependable, adaptable and accountable manner at country level; and to work in partnership with all stakeholders in support of Member State preparedness.

The report covers the work of the Advisory Group on WHO's work in outbreaks and emergencies with health and humanitarian consequences ([about](#), [members](#)), as well as progress made in the areas of work announced by the Director-General in May 2015 in her address ([A68/3](#)) to Member States at the Sixty-eighth World Health Assembly.

Background

See [WHA68\(10\)](#) Decision on the 2014 Ebola virus disease outbreak and follow-up to the [Special Session of the Executive Board on Ebola](#). Decision includes elements relating to:

- Interim Assessment Panel (see report of [Interim Assessment Panel](#));
- IHRs (see [EB138/20](#) (under Item 8.1), the Report of the First Meeting of the Review Committee on the Role of the IHRs in the Ebola Outbreak and Response. See [PHM Comment](#) on this item);
- Global Emergency Workforce
- Contingency Fund
- Research and Development
- Health Systems Strengthening
- Way Forward

9.1B 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

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- [In focus](#)
- [Background](#)
- [PHM comment](#)
- [Notes of discussion at EB138](#)

In focus

The Board will consider [EB138/28](#) which;

1. recommends that the proposed database regarding diagnostic, preventive and therapeutic products (starting with haemorrhagic fevers) be vested in the proposed Global Observatory on Health Research and Development; and
2. outlines five work streams directed to enhancing WHO's capacity to facilitate access to diagnostic, preventive and therapeutic products for infectious diseases that may cause public health emergencies.

Background

Resolution [EBSS3.R1](#), adopted in January 2015 by the Executive Board at its [special session on the Ebola emergency](#), is an omnibus resolution addressing a wide range of issues emerging from the Ebola crisis.

In OP32 the Director-General was requested to provide to the Executive Board at its 138th session options for strengthening information sharing and for enhancing WHO's capacity to

facilitate access to diagnostic, preventive and therapeutic products, including the establishment of a global database, starting with haemorrhagic fevers.

The Secretariat report ([EB138/28](#)) responds to this request.

The Secretariat report addresses separately:

1. options for strengthening information sharing on diagnostic, preventive and therapeutic products, including the establishment of a global database, starting with haemorrhagic fevers; and
2. enhancing WHO's capacity to facilitate access to diagnostic, preventive and therapeutic products for infectious diseases that may cause public health emergencies

In relation to the first task the Secretariat suggests that the mandate of the proposed Global Observatory on Health Research and Development ([WHA66.22](#), 2013) be extended to include the proposed database.

In relation to the second task [EB138/28](#) reports on the development of a 'blueprint' for R&D preparedness and rapid research response. Developing this blueprint involves five different workstreams:

1. Prioritization of pathogens and development of an operational plan;
2. Research and development preparedness: gap analysis and identification of research priorities;
3. Organization, coordination of stakeholders and strengthening of capacities;
4. Assessment of research and development preparedness levels and the impact of interventions; and
5. Funding options for research and development preparedness and emergency response.

For further background on the ebola crisis see:

1. The [Ebola section](#) on the WHO website,
2. The [report](#) of the Ebola Interim Assessment Panel,
3. Documents prepared for the EB Special Session on the Ebola crisis ([EBSS3](#)),
4. Resolution [EBSS3.R1](#),
5. [Summary records](#) of EBSS3.

9.2A Draft global health sector strategies: HIV 2016-21

Contents

- [In focus](#)
- [Background](#)
- [PHM comment](#)
- [Notes of discussion at EB138](#)

In focus

A draft strategy has been developed ([EB138/29](#)) to define the health sector contribution towards the 2030 Agenda for Sustainable Development target of eliminating the AIDS epidemic by 2030. EB138/29 includes a summary of the draft global health sector strategy (2016-21). The full draft strategy is [here](#).

This draft health sector strategy has been developed in parallel with the UNDAIDS 2016-21 Strategy ([here](#)).

The draft strategy has been developed jointly with draft global strategies on viral hepatitis and sexually transmitted infections ([here](#)), using a common universal health coverage framework.

The Board is invited to consider the draft global health sector strategy on HIV 2016–2021.

Presumably a draft resolution to forward to the Assembly is currently being prepared.

Background

The [global health sector strategy on HIV/AIDS, 2011–2015](#) ended in December 2015. In May 2014 the Sixty-seventh World Health Assembly discussed progress made in implementing the strategy ([A67/40A](#)) and the Secretariat was requested to draft a global health sector strategy on HIV for the post-2015 period.

PHM comment

Strengths

The strengths of the draft strategy include:

- the ambitious but achievable vision, goal and 2020 targets,
- the discussion of national accountability,

- the discussion of the role of civil society in the AIDS response, including in demanding accountability (see [Fig 10](#) of UNAIDS Strategy),
- the focus on measurement, evidence and innovation.

There are some other areas where both strategies are somewhat thin.

Funding

Both the WHO draft strategy and the UNAIDS Strategy emphasise the need to ‘fast track’ the upscaling of the AIDS response. See [Fig 8 from draft strategy](#). Both emphasise that significant new money will be needed.

In some degree this new money will have to be mobilised from domestic sources, in particular, various forms of taxation. Both strategies are silent on the question of tax avoidance and tax competition and the need for a multilateral agreement on tax avoidance. This is a serious weakness.

There are references to equity throughout both strategies but no references to the conditions for solidarity in the response to AIDS, including a willingness to contribute to tax funded service programs.

There will also be a need for additional funds through ‘development assistance’. In this context the ‘name and shame’ [Fig 15 from the UNAIDS Strategy](#) is relevant. Japan, Germany, France, Italy, Canada and Australia all appear to be shirking their responsibilities with respect to contributing to HIV funding.

Health care financing and service delivery

Strategic directions 2 & 3 deal respectively with interventions and service delivery. These sections are cast in quite general terms and there is no discussion of broad questions of health system design questions such as: (i) single payer versus competitive health insurance markets; (ii) tax based health care funding versus social (and other forms of insurance); (iii) mixed service delivery versus public sector service delivery.

These variables make a huge difference to integration of services, information systems, procurement systems, quality assurance and workforce development. The challenge of ensuring equity in the context of stratified health care funding arrangements are well known. The challenges of achieving high standards of care and prevention in the context of fragmented service delivery are well known. WHO should be providing guidance in both of these areas. The continued repetition of UHC is not sufficient.

Unique national identifier

There is a reference to the value of a unique national identifier to ensure data linkage for data systems and follow up ([page 31](#) of draft health strategy). This is mentioned with specific reference to HIV/TB co-morbidity; not discussed elsewhere in the draft strategy and not at all in the UNAIDS Strategy. Clearly there are privacy and data security issues associated with this kind of facility but it is also clear that data linkage could be used in tracking the epidemic

and ensuring quality and integration of services. It is surprising that there is no discussion of this.

Multiple competing vertical funding agencies

The challenges presented by a multiplicity of vertical funding agencies are notorious. They include: (i) barriers to coordinated person centred care from the fragmentation of service programs; (ii) the opportunity costs borne by government seeking to liaise and coordinate with various different funders; and (iii) domestic brain drain from public employment to better paid foreign funded programs.

The only reference to these problems is in a very limited discussion in the UNAIDS Strategy [here](#)). It is good news if these problems have all been solved; if not they should have been addressed.

In view of the emphasis on measurement and national accountability the lack of any recommendations for monitoring donor incoordination is surprising.

9.2B Draft global health sector strategies: Viral hepatitis 2016-21

Contents

- [In focus](#)
- [Background](#)
- [PHM comment](#)
- [Notes of discussion at EB138](#)

In focus

The Board is invited to consider the draft global health sector strategy on viral hepatitis 2016–2021, presented in summary form in [EB138/30](#) and in full [here](#). The draft strategy has been developed jointly with the draft global strategies on HIV and sexually transmitted infections, using a common universal health coverage framework.

Background

Resolution [WHA67.6](#) (2014), inter alia, urged Member States to develop and implement coordinated multisectoral national strategies for preventing, diagnosing, and treating viral hepatitis based on the local epidemiological context, and requested the Director-General to examine the feasibility of, and strategies needed for, the elimination of hepatitis B and hepatitis C with a view to potentially setting global targets.

PHM comment

The global situation described in this draft strategy reflects a gross shortfall in terms of delivery against needs. Hepatitis, especially B & C, is responsible for a very high burden of disease. The absolute number of deaths exceeds TB, HIV or malaria (see Fig 2, p4). Vaccines, treatments and preventive strategies are available but not adequately deployed.

Some of the main causes for the shortfall, against potential, in relation to hepatitis include:

- Cost of constructing clean water and sanitation infrastructure in low resource and emergency settings
- Ideological opposition to harm reduction strategies,
- Low levels of achievement of birth dose HBV vaccine,
- Cost of diagnostics and drugs for treating HBV and HCV,
- Unsafe &/or unnecessary use of injections in health care settings.

Unmet but meetable need offers huge opportunity. But the draft strategy does not offer a plausible scenario for overcoming the barriers.

The draft strategy is otherwise comprehensive and sensible.

The decision to structuring the draft strategy around the three dimensions of the UHC cube has the effect of downplaying the issues of health systems configuration although it is clearly acknowledged in the draft.

“An effective hepatitis response requires robust and flexible health systems that can sustainably deliver people-centred care across the full continuum of services to those populations, locations and settings in greatest need. The hallmarks of such health systems are: a strong health information system; efficient service delivery models; appropriately trained and distributed workforce in adequate numbers and with an appropriate skills mix; reliable access to essential medical products and technologies; adequate health financing; and strong leadership and governance.” (page 26)

Delivering effective and comprehensive disease programs which are integrated within the broad structures of health care is not just about UHC, important though this is. Critically it is also about the configuration and governance of the health systems through which healthcare is delivered.

The cost of the proposed strategy is significant (see [Fig 8](#)). While middle and upper income countries might expect to fund it out of domestic sources the situation for low and low-middle income countries is not promising, given the lack of donor funding for hepatitis hitherto.

WHO needs to add its weight to the demands for real action on corporate tax avoidance and the pressures on countries to reduce tax revenues (through ‘tax competition’). There is an urgent need for a multilateral tax agreement which addresses both of these issues.

9.2C Draft global health sector strategies: STIs 2016-21

Contents

- [In focus](#)
- [Background](#)
- [PHM comment](#)
- [Notes of discussion at EB138](#)

In focus

In 2006, the Health Assembly adopted resolution [WHA59.19](#) in which it endorsed the Global Strategy for the Prevention and Control of Sexually Transmitted Infections, covering the period 2006–2015 ([here](#)). The final progress report on implementation of the Global Strategy (in full [here](#) and in document [A68/36\(G\)](#)) was considered by the Sixty-eighth World Health Assembly in 2015, with speakers emphasizing the need for a new strategy to be developed ([APSR12](#) and [13](#)).

The current Global Strategy has therefore been updated and is presented to the Executive Board for its consideration (in [EB138/31](#)). The draft strategy (in full [here](#)) which is aligned with the other global health sector strategies, includes innovative solutions and interventions towards eliminating sexually transmitted infections, and is linked to the broader objectives of the 2030 Agenda for Sustainable Development. The draft strategy has been developed jointly with the draft global strategies on HIV and viral hepatitis, using a common universal health coverage framework.

Background

The final progress report on implementation of the Global Strategy 2006-2015 ([here](#)) provides useful background to the revised strategy.

PHM comment

The new draft strategy is to be welcomed. While the presentation of the strategy may be criticised the principles and strategies are comprehensive and sensible.

The Vision (p13) is poorly worded, in particular, the reference to “everybody, however marginalised, has free and easy access to STI prevention and treatment services, resulting in people able to live long and healthy lives” which could be taken as disregarding the wider causes and consequences of marginalisation.

The metrics implied in the Vision, the Goal and the Global Targets are quite mixed. The vision is expressed in terms of the concept of 'zero STI-related complications and deaths' (which corresponds to the box on p5 summarising the burden of disease associated with STIs). The goal is expressed in terms of STI as no longer a 'major public health concern'. The Global Targets are cast in terms of incidence rates, and service coverage.

The third milestone for 2020 is listed on p14 as "70% of key populations have access to a full range of services relevant to sexually transmitted infection and HIV, including condoms". Apart from the metrics implied, this milestone appears to have been deleted from Figure 7 on p15. The list on p14 is also at odds with Figure 7 regarding the HPV vaccination target.

Drafting one strategy for a group of diseases which share a mode of transmission but have different clinical and epidemiological features is not easy, particularly when it is forced into the UHC box (services, populations and funding). Likewise the references to 'key populations' raises questions about the degree to which 'key populations' can be addressed as a generic group and to what extent are they different and require specific policies and strategies?

The decision to force all three communicable disease strategies into the UHC box tends to obscure some of the critical issues the strategy should be clarifying.

Clearly the technical content of preventive and treatment strategies needs to be considered separately from health service delivery issues including the relations between specialist programmes and generalist PHC or between programmes in the community and those in particular settings (prisons etc) or between health promotion programs and clinical programs. However, structuring the strategy within the UHC box privilege the technical 'interventions' and ignores to some extent the service and program delivery questions; most notably the lack of reference to workforce development as a key dimension of the strategy.

The delivery of prevention and treatment for STIs takes place at the conjunction of three different kinds of strategy:

- technical strategies focused on particular diseases;
- service and program delivery strategies (different kinds of service, different settings); and
- strategies to assist public health practitioners to engage with various 'key populations'.

The challenge for the policy makers and programme managers at the national and subnational levels is to ensure that the technical strategies and engagement strategies are most effectively and efficiently realised through the service delivery strategies. It is not clear that structuring these WHO strategies within the UHC box is the best way to assist those policy makers and programme managers, particularly in such a heterogeneous field as STIs.

The frequent references in all three communicable diseases strategies to including interventions in 'national benefit packages' appears to assume health insurance as the principal service delivery framework and disregards other dimensions of health service delivery including PHC as an approach to service delivery; links between treatment services and health promotion and outreach / community engagement programs; the relation between specialist programs and PHC and other more generic services; the concept of

district health systems and the overarching issue of clinical governance. The reference to a “core package” on page 23 provides no guidance at all about delivery systems.

In fact the authors of this strategy are very aware of the service delivery dimensions of this policy as is evident in the reference to a public health approach on p10, ‘strengthening health systems’ from p34, and ‘optimise service delivery’ under research.

The section on implementation and accountability from p44 is promising although there is no mention of how the various groups affected (‘key populations’) might be engaged in the implementation process and accountability relations. There is a reference in the Guiding Principles (p17) to “Meaningful engagement and empowerment of people living with sexually transmitted infections, key populations and affected communities” but it is not clear where this is enacted within the strategies.

The reference to benchmarking is appreciated but this needs to include rich descriptions of service and programme delivery, not just country questionnaires.

The treatment of HPV vaccination is a bit limited. There are opportunity costs associated with adding HPV to the immunisation schedule and these costs vary with the prevailing epidemiology and service delivery capacity. There are also financial risks associated with HPV immunisation arising from graduation from Gavi eligibility. The need for functioning national immunisation technical advisory groups (NITAGs) as discussed in the [SAGE GVAP Assessment Report](#) could have been underlined here.

There are repeated references to the need for further research, including various applications of operations research into service delivery.

There is also a need for new diagnostics, vaccines and antibiotics. The strategy does not include any assessment of the global pipelines for this research and the current investment effort. This may be something that the R&D Observatory could answer. It may be time to delink research into the prevention and control of STIs from its dependence on the profit incentives associated with monopoly pricing.

9.3 Global vaccine action plan

Contents

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- [PHM comment](#)
- [Notes of discussion at EB138](#)

In focus

The Executive Board will consider the third report of the Strategic Advisory Group of Experts (SAGE) on immunization on implementation of the Global Vaccine Action Plan ([GVAP](#)). The Secretariat report ([EB138/32](#)) reproduces the recommendations of the [SAGE Assessment Report](#).

WHA66 in 2013 endorsed the Secretariat's proposed [Framework for Monitoring, Evaluation and Accountability](#) for the GVAP.

Delegates need to read the original [SAGE Assessment Report for 2015](#) because the extract included in EB138/32 includes only the SAGE Recommendations. In particular, delegates should be aware of the overall SAGE conclusions:

In recommending what needs to change, this report focuses on two major problems that are holding back progress in the Decade of Vaccines:

- *The elimination strategies for maternal and neonatal tetanus, and for measles and rubella, and their implementation, are in urgent need of change and adequate resourcing;*
- *The monitoring and accountability framework for the Global Vaccine Action Plan has gaps in its mechanisms for accountability, undermining the translation of the plan's goals into reality.*

These conclusions are backed up by the evidence presented in the main report.

Background

See GVAP home page for the [GVAP](#) and SAGE assessment reports from [2013](#) and [2014](#) including for [2015](#) (en) and [monitoring framework](#).

PHM comment

The SAGE report for 2015 is a very useful report. It sets out clearly the current shortfalls against the GVAP and offers practical suggestions to address these. Its blunt speaking is appreciated. The focus of the SAGE report is on the shortfalls in maternal and neonatal

tetanus, the shortfalls in measles and rubella, and the shortfalls in monitoring, planning and accountability.

The report:

- reviews basic immunisation coverage (based on national DTP3) and identifies the countries where because of weak health systems or conflict and disruption coverage is low;
- reviews specific diseases and highlights maternal and neonatal tetanus and measles and rubella as being well behind the GVAP targets;
 - SAGE comments that *“The funding gap to rid the world of maternal and neonatal tetanus is estimated at \$130 million, which is miniscule compared with the \$1.1 billion spent in 2014 by Gavi, the Vaccine Alliance on its new and underused vaccine programmes.”*
- comments on the speed with which new vaccines against Ebola were developed;
- comments on the introduction of new and ‘under-used’ vaccines, noting the vulnerability of GAVI ‘graduates’; (PHM has previously commented ([here](#)) on the importance of countries having robust capacity to evaluate the need for new vaccines in relation to their specific circumstances; this requires a functioning NITAG);
 - The SAGE report for 2015 comments: *“Progress towards outcomes set out in plans should be reviewed annually by an independent body with technical expertise such as the country’s national immunization technical advisory group (NITAG) and a body with management expertise such as an inter-agency coordinating committee (ICC). In 2014, 123 countries reported having a NITAG, and only 25 of these were Gavi-eligible countries. Only 81 countries had a NITAG that met WHO criteria for functionality, and only 15 of these were Gavi-eligible countries.”* This is clearly something that both WHO regional offices and global partners should be supporting!
- improved data on vaccine pricing
- success factors
 - data quality
 - community ownership
 - vaccine supply (and “moribund procurement systems”)
- leadership (in country) and accountability (country, region, global partners)
 - need for national immunisation plans and national immunisation technical advisory groups (NITAGs)
 - importance of functioning health systems and effective equitable health care delivery
 - SEARO singled out for being behind in its planning
 - global partners *“...should align their efforts and contributions to achieving the GVAP’s goals going forward, both in relation to specific disease targets and to the broader immunization agenda. They can best do this by supporting countries towards better healthcare systems and improved accountability.”* (presumably they are not doing so at this time).

Many but not all of the shortfalls against the targets set in the GVAP are due to poverty, conflict and displacement. Weak health systems, funding anomalies and accountability failures also need to be attended to.

See earlier PHM comment from [WHA68 \(Item 16.4\)](#) on the 2nd GVAP Assessment Report ([here](#)) including commentary on vaccination and:

- [health systems](#)
- [fragmenting impact of vertical funding programs](#)
- [WHO reform](#)
- [pricing, affordability, procurement and logistics](#)
- [introduction of new vaccines](#)
- [data quality and use](#)
- [clinical trial data reporting](#)
- [rubella](#)

See also [PHM commentary](#) on the first GVAP Assessment Report ([here](#)) at WHA67

9.4 Mycetoma

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- [Notes of discussion at EB138](#)

In focus

The EB will consider the proposed resolution ([EB137/CONF./1](#) – Strengthening Control of Mycetoma Disease) and the Secretariat’s updated report ([EB138_33](#)).

It is likely that a resolution based on the Sudan proposal will be adopted for consideration by WHA69.

Background

A proposal for an additional item ([WHA68/1 Add.1](#)) to be added to the WHA agenda (with accompanying resolution) was submitted by Sudan (and co-sponsored by India, Nigeria, Somalia and Mexico).

Basically the draft resolution called for increased attention to mycetoma, including research and for mycetoma to be added to the list of neglected tropical diseases (NTDs).

The item was bounced to EB137 where a revised resolution ([EB137/CONF./1](#) – Strengthening Control of Mycetoma Disease, proposed by Egypt, Jordan & Sudan) was considered. Consideration was supported by [EB137/11](#), a report by the Secretariat on Mycetoma and [EB137/CONF./1 Add.1](#), the Secretariat’s report on financial and administrative implications.

At EB137 there was considerable support for the issue and the resolution to be considered at WHA69 but Sweden, UK and Belgium proposed deferring further consideration to EB138 on the grounds of expense and seeking further advice from regional offices. There was also some debate as to whether mycetoma is a disease or a condition.

PHM notes of debate at EB137 [here](#). Official provisional summary notes of discussion at EB137 [here \(p9\)](#).

The Secretariat report [EB138_33](#) provides descriptive overview of mycetoma (clinical features, aetiology, epidemiology) and summarises WHO’s broad strategy for NTDs and proposed initiatives in relation to mycetoma (including soliciting further funds from donors and partners).

PHM comment

[EB138 33](#) explains that mycetoma infection “is thought to be acquired by traumatic inoculation of fungi or bacteria into the subcutaneous tissue following minor trauma or a penetrating injury, commonly thorn pricks. People of low socioeconomic status who walk barefoot and manual workers, such as agricultural labourers and herdsmen, are those worst affected. ... The disease occurs in tropical and subtropical environments characterized by short rainy seasons and prolonged dry seasons that favour the growth of thorny bushes”.

The global burden of disease attributable to mycetoma is not huge but it is a major problem in particular localities. It appears that it is under-diagnosed and under-reported.

There is clearly a case for further investment in developing preventive strategies, improved diagnosis and effective treatment. It is regrettable that WHO will need to seek donor funding for such increased investment.

Clearly there is also a need for health system development in affected localities, including action around the social and economic factors which contribute to the prevalence of this condition.

10.1A Health workforce and services

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In focus

Three resolutions

The Secretariat has provided a report on Health workforce strengthening, nursing and midwifery and health workforce education ([EB138/34](#)). The report describes progress made in implementing three health workforce resolutions:

- [WHA64.6](#) (2011) on health workforce strengthening
- [WHA64.7](#) (2011) on strengthening nursing and midwifery, and
- [WHA66.23](#) (2013) on transforming health workforce education in support of universal health coverage.

The code

In [EB138/35](#) (in accordance with [WHA63.16](#) (2010) and [WHA68\(11\)](#) (2015)) the Secretariat presents aggregate findings across WHO regions, as derived from the second round of national reporting .

The new global strategy

In resolution [WHA67.24](#), the Assembly requested the Director-General to develop and submit a new global strategy on human resources for health for consideration by the Sixty-ninth World Health Assembly. A summary of the draft strategy is provided in document [EB138/36](#); PHM comment on the draft strategy is [here](#).

A framework for integrated, people centred health services

In accordance with resolution [WHA62.12](#) (2009), the Secretariat has produced a framework on integrated, people-centred health services ([here](#) and also in [EB138/37](#)). PHM comment on proposed framework is [here](#).

Background

Three resolutions

EB138/34 provides all necessary background to these various resolutions.

Second round of reporting under the Code

The WHO Global Code of Practice on the International Recruitment of Health Personnel was adopted by the Assembly in resolution [WHA63.16](#) in 2010.

In May 2013 the Assembly reviewed the results of the first round of reporting on the implementation of the code (in [A66/25](#)).

In May 2015 the Assembly reviewed the report of the Expert Advisory Group on the Relevance and Effectiveness of the code (in [A68/32 Add.1](#)). The provisional summary record of the debate is [here](#) and the decision [WHA68\(11\)](#) was adopted

PHM comment

Three resolutions

EB138/34 reports on meetings, analyses, publications and tools which have been organised by the Secretariat by way of implementing the three resolutions.

It is to be hoped that the global strategy on human resources for health will carry forward in a more comprehensive and strategic manner the initiatives commenced under these three resolutions.

The Code

The increased number of countries who have identified a 'national authority' for the purposes of the Code is good. The number of national authorities who did not submit a national report to the Secretariat by the due date is surprising. However most of the major destination countries appear to have reported. The Secretariat report does not provide a useful analysis of the data collected through the national reports.

It appears that progress with respect to substantive implementation of the Code has been slow, including:

- mandating the provisions of the Code in legislation
- including the provisions of the Code in bilateral agreements
- putting in place comprehensive data collections regarding HRH generally and migration data specifically

[Decision A68\(11\)](#) remains important. Further implementation of the Code will be facilitated by the adoption and implementation of the proposed Global Strategy ([here](#)).

10.1B Draft global strategy on human resources for health: workforce 2030

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- [Notes of discussion at EB138](#)

In focus

In May 2014, the Sixty-seventh World Health Assembly adopted resolution [WHA67.24](#), which requested the Director-General to develop and submit a new global strategy on human resources for health for consideration by the Sixty-ninth World Health Assembly.

The report submitted to the Executive Board ([EB138/36](#)) provides a summary of the draft global strategy.

At the time of writing (late Dec 2015) the draft global strategy has not been published. The relevant page of the Secretariat website ([here](#)) promises that the draft strategy will be available online by mid-January.

Background

The GHWA [synthesis paper](#) lists some of the landmarks in HRH policy making in the recent past:

- the [Joint Learning Initiative](#),
- the [WHO World health report 2006](#),
- the convening of three global forums on HRH (in [2008](#), [2011](#) and [2013](#)), and
- the adoption in 2010 by the World Health Assembly of the [WHO Global Code of Practice on the International Recruitment of Health Personnel](#).

PHM comment

The issues identified and policy reforms set out in EB138/36 and in the draft strategy are of the highest importance. Health systems are constituted by people. The deployment and production of the health care workforce are central to health system strengthening.

The draft global strategy has been produced through a highly consultative process which is described in EB138/36 and in the full strategy document.

The background section of the draft strategy canvasses the importance of addressing health workforce issues and lists four sets of policy levers to address health workforce issues.

These include:

- Policies on production
 - on infrastructure and material
 - on enrolment
 - on selecting students
 - on teaching staff
- Policies to address inflows and outflows
 - to address migration and emigration
 - to attract unemployed health workers
 - to bring health workers back into the health care sector
- Policies to address maldistribution and inefficiencies
 - to improve productivity and performance
 - to improve skill mix composition
 - to retain health workers in underserved areas
- Policies to regulate the private sector
 - to manage dual practice
 - to improve quality of training
 - to enhance service delivery

The draft proposes a sensible goal; articulates a series of important principles; and proposes four objectives:

- optimising the deployment of the workforce;
- improved workforce planning;
- institutional capacity building; and
- improved data for planning and accountability.

In relation to each of these objectives the draft lists policy reforms which countries should consider; lists activities for the Secretariat (assuming the final strategy gets funded); and offers recommendations to 'other stakeholders and partners'. The content of these reforms, activities and recommendations overlap greatly across the four objectives.

From the PHM perspective there are some policy issues which could have been better developed but in general the policy directions identified are sensible.

However, the strategy lacks a convincing implementation dynamic. The implementation drive appears to depend on advocacy and evidence (to achieve 'political will') and on the WHO Secretariat providing data, tools and advice. The strategy is full of 'shoulds' and 'needs' including many good ideas (some of which have been in circulation for many years) but it is not clear why bringing these good ideas together into this strategy will make them easier to implement.

The weak implementation drive evident in this draft strategy reflects the lack of peer accountability among the member states of the WHO. It is a fundamental weakness of the WHO (completely neglected in the current round of 'WHO Reform'). The culture of WHO is characterised by an undue respect for member state sovereignty and the avoidance of peer accountability.

This respect for MS sovereignty regarding health policies stands in sharp contrast to the pressures for economic integration and regulatory harmonisation in relation to trade. The

IMF, WTO and OECD all sponsor rigorous assessments of national policies and performance in relation to finance and trade.

National health workforce policies and performance should be subject to similar international scrutiny and publicly available evaluation. This would put pressure on political leaders, not least because it would support professional and community advocacy at the national and subnational levels.

This is not a call for uniformity. The processes of peer accountability would necessarily have regard to national circumstances. However, the application of the principles which inform this draft strategy to those national circumstances would be critically evaluated.

The draft strategy includes a very useful annex setting out global and regional workforce estimates and projections. The annex introduces an innovative methodology for estimating workforce needs based on workload rather than arbitrary ratios.

10.1C Framework for integrated people centred health services

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- [Notes of discussion at EB138](#)

In focus

In accordance with resolution [WHA62.12](#) (“*Primary health care, including health system strengthening*”, 2009), the Secretariat is developing a framework on integrated, people-centred health services (summarised in [EB138/37](#)), which is designed as a roadmap for countries to foster and guide reforms to reorient health services in a shift away from fragmented, vertical, supply-oriented models, towards models that put individuals, families, carers and communities at their centre

The framework proposes five interdependent strategic goals and related policy options for national action to make health services more integrated and people-centred:

1. empowering and engaging people;
2. strengthening governance and accountability;
3. reorienting the model of care;
4. coordinating services within and across sectors; and
5. creating an enabling environment.

The summary (in [EB138/37](#)) produced for the EB presumably reflects current thinking in the Secretariat. An interim framework was published in March 2015 ([here](#)). This framework is being reviewed in the light of the draft global strategy on human resources for health: Workforce 2030 (PHM comment [here](#)).

Background

Chapter Two of the Interim Framework ([here](#)) locates the proposed framework in relation to:

- the UHC campaign (and the need to consider models of service delivery as well as financing);
- the Alma-Ata Primary Health Care movement;
- the rising pressures associated with NCDs;
- the increased awareness of inequities in health and the need to address the social determination of health;
- the continuing threats of epidemic and disaster and the need to strengthen emergency capabilities and health system resilience.

EB138/37 also emphasises the inter-relations between this framework and the draft global strategy on health workforce (which includes the reform of service delivery as one of its policy strategies).

PHM comment

This is a very good framework. PHM urges that the Executive Board and the Assembly endorse this framework in substance.

There are some areas where PHM would wish to see revision. We note the repeated use of the term 'primary care' among the policy options listed despite the explicit wording of [WHA62.12](#) which is cited as the principal mandate for this framework. One of the critical ideas which is lost in replacing PHC with primary care is the Alma-Ata vision of PHC practitioners and agencies working with their communities to address health care issues and to address the social determinants of health. While there are references to community empowerment and to action on the SDH the concept of PHC practitioners working with their communities for health development has been seriously discounted.

However, the principal weakness of this framework (like the draft Global Workforce Strategy) lies in the lack of implementation drive. The framework is full of excellent policy suggestions, many of which have been circulating for many years. The implementation drivers envisaged in this framework include: political commitment, leadership (distributed leadership across various 'stakeholders'), empowerment (especially of disadvantaged populations), data and evidence, and (through the Secretariat) advocacy and technical cooperation.

This set of drivers could be sufficient to achieve real change but it is not very obvious that it would be sufficient.

Quoting from our commentary on the draft global strategy ([here](#)) which suffers from the same weakness:

The weak implementation drive evident in this draft strategy reflects the lack of peer accountability among the member states of the WHO. It is a fundamental weakness of the WHO (completely neglected in the current round of 'WHO Reform'). The culture of WHO is characterised by an undue respect for member state sovereignty and the avoidance of peer accountability.

This respect for MS sovereignty regarding health policies stands in sharp contrast to the pressures for economic integration and regulatory harmonisation in relation to trade. The IMF, WTO and OECD all sponsor rigorous assessments of national policies and performance in relation to finance and trade.

National health workforce policies and performance should be subject to similar international scrutiny and publicly available evaluation. This would put pressure on political leaders, not least because it would support professional and community advocacy at the national and subnational levels.

Meaningful peer accountability among the member states of WHO would give this excellent framework a much better chance of successful implementation.

10.2 Comprehensive evaluation of the global strategy and plan of action on public health, innovation and intellectual property: progress update

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- [Notes of discussion at EB138](#)

In focus

In May 2015, the Sixty-eighth World Health Assembly adopted resolution [WHA68.18](#), in which the Director General was requested, inter alia, to initiate a comprehensive evaluation of the global strategy and plan of action on public health, innovation and intellectual property ([here](#)). In line with resolution [WHA68.18](#), the Secretariat has published a report ([EB138/38](#)) providing an update on progress made in relation to the evaluation and giving details of both the key points from the inception report and the response of the evaluation management group.

An additional report (EB138/38 Add.1) yet to be published will review the key points from the evaluator's inception report and comments from the ad hoc evaluation management group.

Background

Pre-history of the GSPoA

Since the TRIPS Agreement in 1994 the role of intellectual property (IP) protection in maintaining higher prices and constituting a barrier to access has been controversial within WHO. Particularly after the Treatment Action Campaign (1997-2001) in South Africa and the Doha Declaration on Public Health and Trade there were repeated debates about whether countries were (or should be) using the full range of flexibilities included in the TRIPS Agreement to promote access to medicines. (References and more detail [here](#).)

In June 2001 one of the Working Groups of the WHO Commission on Macroeconomics and Health published a paper ([Scherer and Watal](#), 2001) exploring the use of compulsory licenses, parallel imports, and price controls, for ensuring affordable access to patented medicines in developing countries. It also reviewed the role of corporate charity (drug

donations by research-based pharmaceutical companies) and the role of aid through intergovernmental and nongovernmental organizations.

The debate over access and pricing found its way onto the WHA56 Agenda (May 2003) with Secretariat report, [A56/17](#). The WHA56 adopted resolution [WHA56.27](#) which urged member states (MSs) inter alia to: adapt national legislation to enable the full use of TRIPS flexibilities, and requested the DG inter alia to: promote technology transfer; establish an expert inquiry into IPRs, Innovation and Public Health; and monitor and analyse trade agreements.

The Commission into IPRs, Innovation and Public Health was established 2004, at the end of Dr Brundtland's period as DG, and reported at the Assembly in 2006 which was the year Dr Lee died and so the Commission's report was inherited by Dr Chan. The terms of reference of the Commission were focused on how to reconcile the claims of the manufacturers that monopoly pricing was necessary to fund innovation and the claims of developing countries that high prices were an unconscionable barrier to access.

The final [Report of the Commission](#) was submitted to EB117 (in Jan 2006); was considered by WHA59 (in May 2006) which (in [Resolution A59.24, p32](#)) appointed an intergovernmental working group (IGWG) "to draw up a global strategy and plan of action in order to provide a framework based on the Commission's recommendations, with a focus on research and development relevant to diseases that disproportionately affect developing countries."

The final report of the IGWG was presented to the WHA61 in May 2008, see [Document A61/9](#). A drafting committee was appointed to finalise the proposed global strategy and plan of action but it was not able to resolve all of the disagreements over the draft GSPA. In the end the Assembly adopted [WHA61.21](#): which endorsed "the global strategy and the agreed parts of the plan of action on public health, innovation and intellectual property...". These 'agreed parts' included a commitment "to establish urgently a results-oriented and time-limited expert working group to examine current financing and coordination of research and development" which led to the stream of work designated as follow up of the CEWG report. .

The GSPA was considered again at WHA62 (May 2009) and after much debate an agreed GSPA was adopted (in Resolution [WHA62.16](#), page 29, see also Annex 4 from page 58); see [integrated version of finally agreed GSPA](#).

- Element 1. Prioritizing research and development needs
- Element 2. Promoting research and development
- Element 3. Building and improving innovative capacity
- Element 4. Transfer of technology
- Element 5. Application and management of intellectual property to contribute to innovation and promote public health
- Element 6. Improving delivery and access
- Element 7. Promoting sustainable financing mechanisms
- Element 8. Establishing monitoring and reporting systems

Note that supplementary information was provided to WHA62 in the form of [A62/16 Add.1](#) (Time frames and funding), [Add.2](#) (Proposed progress indicators), and [Add.3](#) (Open paragraphs on stakeholders).

The evaluation of the GSPOA was discussed at EB133 (May 2013). See [EB133/7](#), see official summary record of discussion ([here, from page 78](#)). See PHM report ([here from page 43](#)).

The Secretariat proposed ([EB136/31](#)) the following timeline for the evaluation:

- January 2015: establish evaluation management group.
- March 2015: Finalize and approve the terms of reference for the evaluation, and request proposals for potential members of the evaluation team.
- June 2015: Select the members of the evaluation team and finalize the contracts
- August 2015: Issue an inception report, which presents the plan of action, the timeline and the terms of reference.
- September 2015 to September 2016: Facilitate the evaluation exercise and monitor the outputs.
- January 2016 and May 2016: Report to the Executive Board and the World Health Assembly on the progress of the evaluation.
- October 2016: Review and finalize the evaluation report.
- January 2017 and May 2017: Submit the report to the Executive Board and the World Health Assembly.

WHA68 reviewed [A68/35](#) and considered [EB136\(17\)](#) on the GSPOA and adopted [WHA68.18](#).

See PHM comment and report from WHA68 [here](#).

10.3 Follow-up to the report of the CEWG on R&D: Financing and Coordination – Planning for an open-ended meeting of Member States to discuss progress

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In focus

In resolution [WHA66.22](#) (2013), as part of the follow up of the [report](#) of the Consultative Expert Working Group (see [pre-history](#) below), the Director-General was requested, inter alia, to convene an open-ended meeting of Member States prior to the Sixty-ninth World Health Assembly in order to assess progress and continue discussions on the remaining issues in relation to monitoring, coordination and financing for health research and development.

In response, the Secretariat has prepared a report ([EB138/39](#)) indicating the progress made in the implementation of the strategic workplan and the organization of the open-ended meeting and setting out an indicative agenda.

Background

CEWG Pre-history

See [CEWG pre-history](#) up to and including EB136 in Jan 2015.

WHA68 (May 2015) reviewed two reports: [A68/34](#) dealing with the proposed funding mechanism; and [A68/34 Add.1](#) which reported on progress made in implementing the selected health research and development demonstration projects.

Document [A68/34](#) proposed the Special Programme for Research and Training in Tropical Diseases (TDR) to host a pooled fund towards research and development. The report described how such a fund might be established and managed, as well as its relationship with the R&D Observatory and the future coordination mechanism.

The observatory

In resolution [WHA66.22](#) the Assembly requested the Director-General to establish a global R&D observatory and to review existing mechanisms which could be used to coordinate R&D under the CEWG process.

The Assembly (May 2014) considered the report [A67/27](#) which *inter alia* reported on the work done to date in relation to the Observatory. It reported that the Secretariat has started the process of establishing the Global Health Research and Development Observatory. It proposed the establishment of a global research and development advisory body and the institutionalization of an annual research and development stakeholder conference.

The objectives of the Global Observatory are described in document [A67/27](#). Further information is available at http://www.who.int/phi/implementation/phi_rd_observatory/en/.

Document [A68/34](#) discusses how the the relations between the Funding Mechanism, the Observatory, the Coordination Group and TDR are seen by the Secretariat.

At the end of the debate at WhHA68 the Secretariat noted that the Observatory was expected to be launched in Jan 2016. See [call for publications](#).

The demo projects

The emergence of the demonstration projects is documented [here](#), from the original adoption of the Global Strategy and Plan of Action to the discussions at EB136.

[A68/34 Add.1](#) refers to this history but focuses on the more recent re-evaluation of one merged project and three resubmitted projects.

More in [EB138/39](#).

Funding mobilisation, hosting and coordination

Resolution [A66.22](#) commissioned further exploration of pooled funding and funding coordination.

[A67/27](#) discussed 'Managed coordination' of R&D activities and their funding. It argued that the creation of any new funding mechanism would introduce strong, managed coordination of the research that a new fund would support. The priorities supported under such a financing mechanism would be those identified through the global advisory committee and could be endorsed at the annual stakeholder conference.

In Decision [A67\(15\)](#) the Assembly asked the Secretariat to explore this proposal in more detail and to report, through EB136 to WHA68 in May 2015 on the outcomes of this exploration.

A range of possible hosts for the pooled funding had been considered in [EB134/26](#) (Jan 2014) and the EB was advised that TDR had rated highly on most criteria. In early May 2014 WHO hosted a meeting of the proponents of the four projects selected in the initial round of demonstration projects ([A67/28 Add.1](#)). At this meeting TDR tabled a proposal ([9 May 2014](#)) outlining how it might take on the role of manager of the pooled funds (see also [TDR news release 9 May](#)). While the TDR proposal was not included in the papers published by the Secretariat for WHA67 it was clearly under consideration with several speakers referring to it in debate and its endorsement in [A67\(15\)](#) above.

The Joint Coordination Board (JCB), the top governing body of the Special Programme for Research and Training in Tropical Diseases (TDR) held its annual meeting in Geneva from 23 June 2014 to 25 June 2014. In its media note ([26 June, 2014](#)), TDR recorded the support of the JCB for taking on this role.

The TDR option was further discussed at EB136 ([report of debate](#)) and there was general support plus some specific suggestions which were incorporated into [A68/34](#) which was noted.

More in [EB138/39](#).

UN High Level Panel on Access to Medicines

[Secretary-General Appoints Two Former Presidents, 14 Others as Members of High-Level Panel on Access to Medicines](#) (19 Nov 2015)

See [UNAIDS comment on the appointment of the HLP](#)

The recently appointed United Nations High-Level Panel on Access to Medicines is meeting for the first time on 11 and 12 December in New York, United States of America, to explore innovative approaches of ensuring access to medicines for people most in need. The panel was set up as part of efforts to achieve Sustainable Development Goal 3: ensuring healthy lives and promoting the well-being of people of all ages.

The UN Secretary-General established the panel based on the findings and recommendations of the [Global Commission on HIV and the Law](#) convened by UNDP on behalf of UNAIDS. Its aim is to ensure that everyone can access quality, affordable treatment while incentivizing innovations and new health technologies. The newly established High-Level Panel will review and assess proposals and recommend solutions to policy incoherencies between the rights of inventors, international human rights law, trade rules and public health in the context of access to health technologies.

PHM comment

Overview

The scope of the proposed fund would be to finance R&D projects to address priority research gaps as identified by the Global Observatory and the future coordination mechanism (currently being explored by WHO).

The fund will be managed by the Special Programme, while the Global Observatory and the coordination mechanism will be managed by the WHO Secretariat.

The focus of the fund would be the development of effective and affordable health technologies related to type III and type II diseases and the specific research and development needs of developing countries in relation to type I diseases, taking into account the principles formulated by the Consultative Expert Working Group on Research and Development: Financing and Coordination, namely delinkage of the delivery price from research and development costs, the use of open knowledge innovation, and licensing for access.

The contractual arrangements for the funding of projects will ensure that any future health technologies financed through the fund will be accessible to those in need. Arrangements could include clauses on at-cost or preferential pricing, non-exclusive licensing agreements or licences to WHO or the Special Programme.

The priorities of the fund would be informed by the analysis of the research landscape provided by the Global Observatory.

The Health Assembly, on the recommendation of the Programme, Budget and Administration Committee of the Executive Board, would decide on the allocation of the research and development fund to be apportioned to support research and development projects and to support the Global Observatory and the coordination mechanism

A new scientific review group would be established within the Special Programme under the governance of its Joint Coordinating Board. The Joint Coordinating Board would approve the final selection of projects as submitted by the scientific review group.

There are weaknesses in the current proposals but they do represent a step towards public funding of R&D and delinking.

Funds mobilisation

PHM believes that voluntary funding of the system will prove to be unsustainable and that WHO will in due course need to return to a treaty with mandatory contributions.

Broader scope of R&D

In the [KEI statement](#) to the 2014 Assembly, HAI and KEI argued that the purposes to be addressed by this CEWG initiative should be widened to include the development of new antibiotic drugs, better low cost diagnostics, basic research in areas of particular interest to

all member states, and the funding of independent clinical trials to evaluate the efficacy of pharmaceutical drugs.

Other items on the EB138 agenda (see especially [9.2 STIs](#)) illustrate the need to broaden the range of medical products to be included under this mechanism.

Trade agreements

In the [KEI statement](#) to the 2014 Assembly, HAI and KEI argued for: need to confront more directly the barriers to access to treatment which arise from trade agreements. TRIP plus provisions are standard in contemporary plurilateral trade agreements.

Proceeding with the new system does not preclude WHO taking a more active stand in relation to the full use of TRIPS flexibilities and a moratorium on trade agreements which raise new barriers to affordability.

See note above about the new UN HLP on access.

10.4 Substandard/ spurious/ falsely-labelled/ falsified/ counterfeit medical products

Contents

- [In focus](#)
- [Background](#)
- [PHM comment](#)
- [Notes of discussion at EB138](#)

In focus

The bottom line

At the heart of this item are two issues which in theory are quite unrelated: first, the quality of medicines (including spurious and substandard medicines) on the market; and second, the assertion and protection of intellectual property rights associated with particular medicines. These two issues might have remained separate except for the adoption, by WHO, of the term 'counterfeit' (which legally refers to trademark violations), to refer to spurious and substandard medicines. The continuing use of the term counterfeit conflates the public health problem of spurious and substandard medicines with the tort (civil wrong) of breaches of intellectual property rights (IPRs), including patent rights as well as trademark rights, and thus links spurious and substandard regarding quality with generic status.

Advocates for generic competition, as a means to reduce the prices of drugs, including the full use of TRIPS flexibilities (including compulsory licensing and parallel importation), have been concerned that propaganda, largely emanating from big pharma, which conflates quality with IP status through the use of the term 'counterfeit', has been directed to encouraging countries to adopt medicines laws which are TRIPS + in the sense that they preclude the use of TRIPS flexibilities.

The term SSFFCMP (or SFC) has come into use because agreement on an alternative definition regarding spurious medical products has not been achieved. The Member State Mechanism (MSM) is the latest structure established within WHO to drive action on quality of medicines whilst not creating new barriers to the entry of generics.

The MSM is governed by a set of Objectives (in [Annex 2](#) to WHA6.19), an Agreed Workplan ([Annex 2](#) to A/MSM/2/6, Nov 2013), and a list of prioritised activities ([Annex 3](#) of A/MSM/3/3).

[The following summary of the issues up for consideration at EB138 should be read as a continuation of the previous sequence, summarised under [time lines](#) below.]

The fourth meeting of the MSM for SFC medical products was held in Geneva, Switzerland on 19 and 20 November 2015. The mechanism discussed the range of prioritised activities ([here](#)) from the agreed [workplan](#), including:

- Activity A. Recommendations for Health Authorities engaged in the detection of SSFFC medical products (draft discussed (Annex 1 to [A68/33](#) appears to be the most recent public version), training resources sought, one year extension decided);
- Activity B. Focal point network for the exchange of information among Member States and ongoing virtual exchange forum (draft TOR discussed and [adopted \(Appx1\)](#) as amended);
- Activity C. A working group to survey “track and trace” models (existing models surveyed [here \(Appx2\)](#), one year extension agreed);
- Activity D. WHO work on access to quality, safe, efficacious and affordable medical products (review [presented \(A/MSM/4/4\)](#), concept note requested regarding element 8(c):
 - Increase the knowledge and understanding about the links between the lack of accessibility/affordability and its impact on the emergence of SSFFC medical products and recommend strategies to minimize that impact;
- Activity E. Communication and awareness raising materials (see UK [submission \(A/MSM/4/5\)](#));
- Activity F. Economic impact of falsified and substandard medicines ([report \(A/MSM/4/6\)](#) discussed, cost estimates controversial - see [TWN](#));
- Activity G. Budget and prioritised activities for MSM5
 - Expert working group on definitions; see [TWN](#);
 - Activities which fall outside the SFC mandate (existing contested [document \(Appx3\)](#) reviewed);
 - The issue of **transit** to be considered by Steering Committee of the MSM (see WHO Watch review [here](#); also [Abbott \(2009\)](#), [Seuba \(2009\)](#), [Baker \(2012\)](#), [Saez \(2013\)](#), [Chee \(2014\)](#));

The methodology for the review of the MSM was also discussed.

Useful links

Previous PHM commentaries on SFC discussions

- WHA68 (May 2015) [here](#) (includes report of 3rd meeting of MSM & postponement of review of MSM)
- EB136 (Jan 2015) [here](#) (considered report of 3rd meeting of MSM)
- WHA67 (May 2014) [here](#) (considered report of 2nd meeting of MSM)
- EB134 (Jan 2014) [here](#) (considered report of 2nd meeting of MSM)

WHO web pages

- WHO GB [SFC page](#); includes links to
 - WG of MS on SFC (2011)
 - OEWG on activities, actions and behaviours (July 2013)
 - meetings 1-4 of MSM on SFC (including papers circulated for each meeting)
- WHO SFC [home page](#), includes links to
 - MSM [page](#)

- WHO surveillance and monitoring for SFC products ([here](#))

TWN reports (thanks to KEIOnline)

- 26 Nov 2015 Expert working group on SSFFC definitions established ([here](#))
- 20 Nov 2015 Socio-economic impact study of SSFFC medicines is “propaganda”, says South ([here](#))
- 6 June 2014 Governmental pushback on industry role in medical product regulation ([here](#))
- 30 July 2013 Members agree to list of behaviors linked to compromised medical products ([here](#))
- 24 July 2013 Slow progress in WHO Open Ended Working Group on SSFFC medical products ([here](#))
- 30 July 2013 Members agree to list of behaviors linked to compromised medical products ([here](#))
- 6 June 2013 South to introduce resolution on access to medicines ([here](#))
- 26 Jan 2012 New compromised medicines mechanism agreed, some concerns remain ([here](#))
- 10 Nov 2011 'Member State' mechanism on comprised medical products ([here](#))
- 9 March 2011 QSE Working Group divided, IMPACT Secretariat moves to Italy ([here](#))
- 8 Mar 2011 Members meet to shape role in QSE, examine IMPACT ([here](#))

TWN documentation of IMPACT saga

- [Sangeeta Shashikant \(2010\)](#)

Background

The pre-history of the SFC saga

[The pre-history of the SFC saga](#) (from WHA68)

Time lines

IMPACT was established in 2006 with WHO Secretariat support and participation.

A report regarding WHO's role in IMPACT appeared on the EB agenda in Jan 2009 ([EB124/14](#)) with a draft resolution endorsing WHO's involvement in IMPACT.

Two further reports were submitted to the WHA62 (May 2009), [A62/13](#) on 'counterfeit medical products', and [A62/14](#) on IMPACT, but these were not discussed owing to the H1N1 epidemic.

The issue returned to WHA63 in May 2010 with Documents [A63/23](#) and [A63/INF.DOC./3](#).

OE IG WG

WHA63 adopted [WHA63\(10\)](#) which called for an open ended intergovernmental working group (OE IG WG) on SSFFCMPs. The OE WG of MS on SFC met from 28 Feb-2 Mar,

2011 (see [web page](#)) but in its report to WHA64 ([WHA64/16](#)) it sought an extension of time for a further meeting which was approved.

The second meeting of the OE WG of MS on SFC met in Geneva from 25-28 October 2011 ([see](#)) and reported to EB130 (Jan 2012) in Document [EB130/22](#). The WG proposed (in [EB130/22](#)) a draft resolution for the EB to recommend to the Assembly which would mandate a new Member State Mechanism (MSM) for “international collaboration among Member States, from a public health perspective, excluding trade and intellectual property considerations, regarding “substandard/spurious/falsely-labelled/falsified/counterfeit medical products” in accordance with the goals, objectives and terms of reference annexed to the present resolution”. The draft resolution was adopted as amended ([EB130.R13](#)) and forwarded to WHA65 in May 2012.

WHA65 (May 2012) reviewed the resolution as proposed in [A65/23](#) and after a long and vigorous discussion the draft resolution, establishing a Member State mechanism (MSM) on substandard/spurious/falsely-labelled/falsified/counterfeit medical products (SSFFC), was approved (as [WHA65.19](#)).

1st meeting of MSM

The MSM on SFC was [launched](#) in Buenos Aires 19-21 Nov 2012 and the report of its first meeting ([EB132/20](#)) was considered by EB132 (Jan 2013). Important points from the report of the first meeting:

- There was agreement on how the MSM would operate; but
- There are a lot of square brackets in the draft Work Plan;
- The meeting had not been able to establish a Steering Committee (waiting on nominations from each region of two vice-chairpersons) and did not have a Chairperson (which was emerging as a critical issue);
- The meeting decided to establish an open-ended working group to identify the actions, activities and behaviours that result in SSFFC medical products;
- The meeting decided to progress work on those activities under areas 1, 2, and 3 of the workplan that were agreed.

SFC returned to WHA66 (May 2013) supported by [A66/22](#) which records that the MSM had met in BA in Nov 2012; that the work plan was not fully agreed upon but that there was a commitment to an OE MS WG on Actions, Activities and Behaviours which drive SFC. A Steering Committee was established but there was no agreement on the chairperson.

[A66/22](#) was noted and the Assembly decided in [A66\(10\)](#) to recommend that the chairmanship of the Steering Committee of the Member State Mechanism should operate on the basis of rotation, on an interim basis, without prejudice to the existing terms of reference of the mechanism.

2nd meeting of MSM

The Assembly in May 2014 considered [A67/29](#), (which forwarded [EB134/25](#) from the EB to the Assembly) conveying the report of the second meeting of the MSM, held in late November 2013.

The MSM had:

- considered and adopted the report of the OEWG on actions, activities and behaviours (Appendix 1 of [EB134/25](#));
- reviewed the Secretariat's global surveillance and monitoring project ([here](#));
- approved continuing discussion on strategies for regulating actions, activities and behaviours;
- adopted the revised work plan ([Appendix 2](#));
- noted the budget shortfall ([Appendix 3](#)) and asked for a full report to the WHA67;
- authorised an EWG, to be led by Argentina, "to continue the work of the Open-ended working group on actions, activities and behaviours that result in SSFFC medical products" ([here](#));
- authorised an EWG, to be led by India, to focus on element 5(b) of the work plan on the identification of activities and behaviours that fall outside the mandate of the Mechanism (See Appendix 2 of [WHA67/29](#));
- agreed that next interim Chair would be Argentina;
- agreed to hold "an informal technical meeting, open to all Member States, to finalize the outcomes of the electronic consultations would be held before the third meeting of the Member State mechanism"; and
- agreed that the third meeting of MSM would be in the week of 27 October 2014, to be preceded by a meeting of the Steering Committee to review the system of chairing through the rotation of vice chairs;

Issues discussed at 3rd meeting of MSM

The 68th Assembly reviewed [A68/33](#) which had been considered by the EB in January, and also Decision [EB136\(1\)](#), in which the Board recommended to the Assembly, in accordance with the request of the Member State Mechanism (MSM), that the review of the Mechanism be postponed by one year to 2017.

[A68/33](#) includes the report of the third meeting of the Member State Mechanism for SSFFCMPs, which was held in Geneva, Switzerland 29 October to 31 October 2014.

The third meeting of the MSM reviewed (and apparently approved) the outcome of the informal technical meeting on recommendations for health authorities to detect and deal with actions, activities and behaviours that *result in SSFFC*, reviewed the outcome of the informal technical meeting on element 5(b) of the work plan on the identification of activities and behaviours that *fall outside the mandate* of the mechanism, and reviewed a proposal by the Steering Committee on proposals and priorities for implementation of the work plan.

Annex 1 (to [A68/33](#)) is the outcome document from an informal technical meeting designed to provide advice to national and regional regulatory authorities regarding actions, activities and behaviours which result in SSFFCMPs. It is a revision of an earlier document shared with the EB in Appendix 1 of [EB134/25](#). The revised document covers monitoring, detection, assessment, investigation and prevention. It appears to have been adopted by the MSM and will inform further activities in the workplan of the MSM, in particular Activity A (Annex 3).

Annex 2 (to [A68/33](#)) is a report to the MSM from an informal technical meeting tasked with revising the list of actions, activities and behaviours that fall outside the mandate of the

mechanism. The informal technical group did not reach consensus on the title, a paragraph in the introductory section nor clauses 3 and 7 of the document.

The debate over the introductory paragraph appears to involve words suggesting that actions, activities and behaviours which fall outside the mandate of the Mechanism “will not face unjustified regulatory actions, in order not to hamper access to quality, safe and efficacious medical products”.

The debate over Clause 3 appears to focus on whether deviations from GMP “which do not compromise the quality or which do not pose a health risk” should lie within or beyond the mandate.

The debate over Clause 7 is about the seizure of medical products in transit. It appears that the critics of the EU seizures (see below) want to declare the seizure “of medical products in transit, which are in compliance with the regulatory requirements of the country of export and the country of final destination” as outside the mandate and therefore not justified on the grounds of SSFFC.

The MSM requested the Steering Committee to undertake further consultations on the document with a view to proposing language for the remaining issues in the paper for submission to the fourth meeting of the Member State Mechanism on SSFFC.

The mechanism revised and agreed the list of prioritized activities for 2014–2015 ([Annex 3](#)). This annex needs to be read in conjunction with paragraph 7 of the main MSM report which indicates which countries or the Secretariat will lead the various activities. It also refers to the agreed workplan previously shared with the EB in [EB134/25 Appendix 2](#).

The report notes that the MSM ‘expressed concern over the unfunded activities in the budget’.

[Now return to [in focus](#) to pick up the threads under discussion at this EB.]

PHM comment

The bottom line

The SFC struggle is critical with respect to affordable access to quality, safe and efficacious medicines.

The big pharma strategy is:

- first, to conflate the issue of QSE compromised medicines (SSFFCMPs in WHO speak) with asserted breaches of IPRs;
- second to create a global panic around the fear of ‘counterfeit medicines’ based on the (real) problem of QSE compromised medicines; and
- third, encourage countries to adopt laws and treaties which have the effect of reducing and restricting access to cheap (quality, safe and efficacious) generic medicines (eg through in transit seizure, patent linkage, and domestic laws which preclude the use of TRIPS flexibilities).

Big pharma is supported in this campaign by the governments of the rich countries, in part because they are IP exporters, but in part because of their commitment to corporate globalisation.

The countries, NGOs and social movements working towards access to affordable safe and efficacious medicines are seeking to:

- achieve a practical definition of SFC medicines which clearly distinguishes between QSE risk and IP status;
- establish technologies and regulatory structures which prevent QSE compromised medicines from accessing medicines markets.

While the fundamental issues are simple the policy development and political maneuvering is taking place around the 'prioritised activities' (activities A-G, [here](#)) referred to above, within an almost impenetrable snowstorm of processes, bodies, acronyms and documents.

While the WHO processes grind slowly, big pharma, and its various supporters and cheerleaders, are pursuing their extreme IP agenda through trade agreements (including the TTP and TTIP) and national / regional regulations (notably the EU regulations directed to seizure of medicines in transit on suspicion of their breaching IPRs in the countries of transit).

PHM urges MS representatives to keep the fundamental issues (summarised above) uppermost in mind in evaluating the report from the MSM and participating in the debate and keep in mind also SDG Goal 3 (Ensure healthy lives and promote well-being for all at all ages) including Target 3.8: 'achieve universal health coverage (UHC), 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* .

Critical issues which may be highlighted in the debate at EB138 include:

- in transit seizure (links above) and whether it falls outside the mandate of the MSM ([Appx3](#));
- membership, procedures and funding of the EWG on definitions ([para 15\(ii\) of EB138/40](#));
- recommendations for regulatory authorities ([Annex 1 to A68/33](#));
- 'track and trace' technologies ([Appx2](#)); links to in transit seizure; integrity and security of data systems;
- communications and awareness raising ([Activity E](#));
- 'socio economic impact' ([Activity F](#));
- continued funding of the MSM process;
- methodology for the scheduled review of the MSM process.

PHM urges NGOs and community organisations and networks to disseminate, publicise and advocate around the issues at stake in this SFC struggle and in particular to hold MS representatives accountable for the policy positions advanced in the governing bodies of WHO.

PHM urges NGOs and community organisations following the SFC struggle within the WHO to strengthen the links with those activists who are mobilising against the extreme IP agenda in the context of trade agreements and EU regulations.

10.5 Addressing the global shortages of medicines, and the safety and accessibility of children's medication

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- [Notes of discussion at EB138](#)

In focus

Many older, important, generic medicines, and others with a limited manufacturing base, are among those most vulnerable to global shortages. The report ([EB138/41](#)) indicates that a global approach to the matter needs to deal with supply side failure and market shaping.

Background

See [EB138/41](#).

More references

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Metzger, M. L., A. Billett and M. P. Link (2012). "The Impact of Drug Shortages on Children with Cancer — The Example of Mechlorethamine." *New England Journal of Medicine* 367(26): 2461-2463, from <http://www.nejm.org/doi/full/10.1056/NEJMp1212468>.

<http://www.fda.gov/Drugs/DrugSafety/DrugShortages/default.htm>

PHM comment

Drug shortages constitute a serious problem and there is a strong case for WHO to pay closer attention to causes and solutions. As [EB138/41](#) observes the causes can be very different across different settings.

EB138/41 is a very useful analysis of the problem, the causes and possible solutions. It is not clear that the evidence is sufficient to initiate policy action immediately. However, it would be appropriate for the EB to commission further examination of particular aspects of causation and particular policy strategies.

Two possible causes which are not explicitly mentioned in EB138/41 are:

- unreasonably stringent regulatory standards in some jurisdictions which have the effect of raising the cost of production beyond profitable for export into those markets (and the role of big pharma in promoting such standards);
- the oligopoly structure of the medicines and vaccines industries with mergers and acquisitions reducing competition in particular markets (in addition to the anti-competitive consequences of soft long patents with hard policing).

It seems likely that a resolution mandating appropriate investigations will be considered by the Board. These should include:

- options for a globalised notification system
- analysis and understanding of the costs of research and development for medicines for uncommon diseases in children (para 19(f) from EB138/41);
- options regarding legislative principles, regulatory strategies and capacity, and monitoring of medicines for children; (as referred to in para 19(g) of EB138/41);
- a review of different product specifications for marketing approval required in different jurisdictions including WHO's prequalification standards;
- consideration of a global observatory which might provide comparative data regarding the cost elements of market prices in different markets;
- options for global standards regarding pricing levels with a view to addressing shortages due to prices being too low;
- research into paediatric access to medicines and the disease burden associated with access barriers.

11.1 Financing the Programme Budget 2016-17

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- [Notes of discussion at EB138](#)

In focus

[EB138/42](#) reports on the outcomes to date of the financing dialogue and the status of the financing of the Programme budget 2016–2017.

Background

PB16-17 is framed by GPW12, 2014–2019, which was set out in [A66/6](#) and approved through [WHA66.1](#). GPW12 uses six broad categories of work' ([para 144](#)) and 30 'programme areas' within categories.

See [A68/7](#) for PB16-17 and Resolution [WHA68.1](#) which endorsed it. See PHM [comment on PB16-17 at WHA68](#).

See [A68/INF/7](#) for more info on budget process. For more financial information see the [Portal](#)

See PHM commentary on [Item 12.1 at WHA68](#). This was a review of PB14-15 including useful information about the financing dialogue.

For further information about the financing dialogue see: <http://www.who.int/about/finances-accountability/funding/financing-dialogue/en/>

PHM comment

The underfunding of WHO and the donor chokehold over the Secretariat's work program are shameful acts of global health vandalism. It has led to:

- critical limitations on Secretariat capacity to carry out its job;
- substantial distortions of the mandate of the governing bodies by the donors who choose what they will or will not fund and, because of the freeze on ACs, have almost total power over the budget; and
- exacerbation of silo behaviour and organizational fragmentation as units, clusters and regions compete for donor visibility and funding.

The % of the PB16-17 with assured funding is estimated to be 80%. Better than previously but seriously unstable. 70% of the budget is funded by VCs, 63% of which are tightly earmarked. In view of the budget lines which have to be funded through ACs, this leaves the governing bodies with very little flexibility.

The alignment of the expenditure budget to global health priorities is skewed by the knowledge of what the donors will and will not fund. However, the actual funds mobilised for agreed budget lines is also very unbalanced. See [Fig 1](#) from WHA68/6 (regarding PB14-15) which depicts the serious under-funding of social determinants, NCDs and 'integrated people-centred health services

PHM appreciates the need for the Department for Coordinated Resource Mobilization within the DirectorGeneral's Office, and the ('end to end resource mobilization process') attempting to coordinate resource mobilization focal points from each region and cluster. It is a shame that it wasn't done before.

Member state delegates are urged to lift the freeze on the total budget and lift the freeze on assessed contribution. Donors are urged to untie their donations.

11.2 Scale of assessments

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In focus

The Board will be invited (in [EB138/43](#)) to consider the revised scale of assessments, based upon the new United Nations scale, together with a draft resolution recommending its adoption by the Sixty-ninth World Health Assembly, for implementation with effect from the second year of the biennium 2016–2017.

Background

See WHO PB [web portal](#).

PHM comment

Unfreeze the ACs!

Untie the VCs!

Lift the donor chokehold over WHO!

12.1 Evaluation: update and proposed workplan for 2016–2017

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In focus

[EB138/44](#) provides a brief progress update on the ongoing evaluative work; and presents, for approval by the Board, the proposed evaluation workplan for the biennium 2016–2017, incorporating both the corporate and decentralized evaluations. The workplan has been developed in consultation with senior managers across the Organization, and discussed with the Independent Expert Oversight Advisory Committee.

Background

Evaluation policy set out in [EB131/3](#) and approved in Decision [EB131\(1\)](#) (2012)

[Framework](#) for strengthening evaluation and organizational learning in WHO

Evaluation workplan for 2014-15, presented in [EB135/5](#) and approved by [EB135](#).

PHM comment

The workplan appears to be sensible and constructive. PHM has expressed some concern about WHO's evaluation practices in previous commentaries. See [PHM comment](#) on the Evaluation Report presented to EB136 (Jan 2015) in [EB136/38](#).

12.2 Real estate: update on the Geneva buildings renovation strategy

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- [Notes of discussion at EB138](#)

In focus

[EB138/45](#) reports on preliminary studies of the selected design and provides the Board with more information upon which to base a recommendation to the Sixty-ninth World Health Assembly about proceeding with the construction of the annex building as an integral part of the comprehensive renovation strategy.

A draft resolution ([here](#)) is recommended.

Background

Renovation was discussed in May 2013. The report ([A66/42](#)) was noted by the Assembly in May 2013. Several delegates (including the Swiss delegate) [spoke](#) in favour of Option 1.

The project was reviewed at WHA67 (May 2014) in [A67/52](#) and the Assembly adopted decision [WHA67\(12\)](#) authorising the DG to proceed with the planning.

In May 2015, WHA68 noted the Secretariat report ([A68/49](#)) on the Geneva buildings renovation strategy, which was submitted prior to the submission of a more comprehensive technical and financial report to the Executive Board at its 138th session.

12.3 Process for election of DG

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- [Notes of discussion at EB138](#)

In focus

In the document published for this item reference is made to previous reports ([EB134/43](#) and [A67/51](#)) and a previous resolution [WHA66.18 \(2013\)](#) regarding the election of DGs.

The purpose of [EB138/46](#) is to raise further procedural and managerial issues including:

- the leave status of internal candidates,
- the candidates' forum,
- the electronic voting system,
- support for nominated candidates, and
- opportunity for nominated candidates to address the Health Assembly before the vote.

The elaboration of these issues in EB138/46 is clear.

Background

Necessary background is provided in [EB134/43](#) and [A67/51](#).

Richard Horton (Dec 16) form guide (per Twitter)

- WHO DG criteria: 1) Diplomate 2) Manager 3) Inspiring 4) Consider UN-in, but WHO-Outsider 5) < 50 years 6) Female 7) Africa
- At dinner tonight Peter Piot states for the record that he is not standing for WHO Director-General.
- Here are the candidates so far (as reported to me second hand).
- France: Philippe Douste Blazy.
- Iraq: Ala Alwan.
- Mali: Michel Sidibe.
- Nigeria: Babatunde Osotimehin or Muhammad Pate. The government will have to decide which to support, of course.
- Botswana: Tshidi Moeti, current RD of AFRO.

PHM comment

Not an easy job.

12.4 Hosted health partnerships

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In focus

In decision [EB132\(10\)](#) (2013) the Executive Board requested the Programme, Budget and Administration Committee of the Executive Board, inter alia, to ensure that the arrangements for hosted health partnerships are regularly reviewed.

This report ([EB138/47](#)) presents a general update on hosted partnerships and the first reviews thereof, which concern the Global Health Workforce Alliance ([EB138/47 Add.1](#)) and the Partnership for Maternal, Newborn and Child Health ([EB138/47 Add.2](#)).

Background

Hosted partnerships

[EB132/5 Add.1](#) describes WHO relationships as including:

- WHO-hosted partnerships:
 - GHWA,
 - PMNCH,
 - UNITAID,
 - RBM,
 - HPSR
- United Nations Joint Inter-Agency programmes (eg UNAIDS),
- UN Inter-organizational facilities (eg UN International Computing Centre),
- Secretariats hosted in WHO pursuant to an international convention such as the WHO Framework Convention on Tobacco Control
- WHO cosponsored programmes (integrated within WHO programme and accountability arrangements but are financially and/or programmatically cosponsored by a number of other agencies): include the
 - Special Programme on Research and Training in Tropical Diseases (TDR);
 - the Special Programme of Research, Development Research and Training in Human Reproduction (HRP);
 - the African Programme for Onchocerciasis Control (APOC),
 - the Codex Alimentarius Commission and
 - the Global Polio Eradication Initiative (GPEI)

- Informal networks and alliances established by WHO to assist it in implementing its programmatic activities (have no formal governance structure and are predominantly led and managed by WHO).

The Dec 2014 list of partnerships and collaborative arrangements [here](#) includes a number of collaborative arrangements which are not hosted by WHO and in which WHO is simply a member. (This group includes [IMPACT](#) which is no longer listed as a ‘hosted’ partnership but whose website continues to be hosted by WHO. See [Shashikant 2010](#) for more on IMPACT.)

The Policy on WHO engagement with global health partnerships and hosting arrangements (the “Partnerships Policy”) was adopted in 2010 by the Sixty-third World Health Assembly (in resolution [WHA63.10](#)).

Decision [WHA65\(9\)](#) is an omnibus decision on WHO Reform. Para 9(c) requests a report to the EB132 on hosted partnerships and lists the principles that should guide the DG in managing such partnerships. [EB132/5 Add.1](#) responded to this requests.

Decision [EB132\(10\)](#) (2013) requested the PBAC to arrange for regular reviews of WHO hosted partnerships.

Two previous reports have been submitted under this mandate: documents [EB134/42](#) (Jan 2014) and [EBPBAC22/2](#) (May 2015).

GHWA

[EB138/47 Add.1](#) provides useful background on the origins and work of the GHWA. It was established in 2006 with a ten year mandate. Significant changes are anticipated in 2016, more below.

For more background see:

- [About the Alliance](#)
- [The Alliance Board](#)
- [Full list of members and partners](#)
- [Partners](#)

The Alliance’s main strategies have been advocacy, knowledge brokerage and convening. It has convened three Global Fora on global health workforce: [2008](#), [2011](#), and [2013](#).

The GHWA was closely involved in the development of (what became) the WHO Code of Practice on the International Recruitment of Health Personnel adopted in 2010 in resolution [WHA63.16](#). More recently, the GHWA convened a number of working groups on HRH in 2014/15 which culminated in a [synthesis paper](#) which informed the development of the current draft global strategy.

An external evaluation of the GHWA was undertaken in 2011. The [report](#) of this evaluation describes the work of the Alliance and comments on the costs and benefits of the partnership with WHO.

Para 10 of [EB138/47](#) reports that the Board of the Alliance will complete its present mandate in 2016 and that discussions are proceeding with a view to ‘a new network mechanism for global engagement, alignment and coordination of the health workforce agenda’. The

'mechanism' will include a HRH 'network' to be hosted by WHO. It is expected that the new 'mechanism' will support the implementation of the new draft global strategy.

Partnership for MN&CH

[EB138/47 Add.2](#) provides useful background information about the PMNCH. Further useful information is contained in the [Independent External Evaluation](#) undertaken in 2013.

Among the programmes and activities of the Partnership have been the production of [knowledge summaries](#); the [partners' forums](#), and the involvement of the Partnership in strengthening the accountability of funders and other partners in relation to the Global Strategy for Women's Children's and Adolescents' Health ([Every Woman Every Child](#)).

The emphasis on accountability is an outstanding feature of the Global Strategy for Women's Children's and Adolescents' Health. The [UN Commission on Information and Accountability](#) (coordinated by WHO) created a framework for strengthening the accountability of funders, countries and other players in the MNCAH space. Responsibility for monitoring the implementation of these recommendations was shared between the independent Expert Review Group, the Partnership for MNCH and Countdown to 2015 and the OECD (see [Three New Reports](#), and also [Accountability Event](#) 2015).

The shared responsibility for tracking and driving accountability under the Commission recommendations is now recognised as a weakness (see 2013 [External Evaluation report](#)) and from 2016 a new Independent Accountability Panel (to be hosted by the Partnership) will assume responsibility for the full task (see [Chapter 9](#) of the Global Strategy 2016-2030).

Para 27 of [EB138/47 Add.2](#) mentions the new Partnership Strategic Plan and Operational Plan but provides no details.

PHM comment

Hosted partnerships and other relationships

Clearly it is essential for WHO to be able to build relationships with a wide range of players with commitments in particular policy areas. The most appropriate arrangements will vary according to the field. In some cases formal 'partnerships' (hosted with WHO or otherwise) will be appropriate; in some cases informal networks managed by the WHO secretariat might be more appropriate.

The review of hosted partnerships in EB138/47 points to some of the strengths of such networking.

The GHWA demonstrates the role of partnerships in *advocacy* to bring issues onto the global and national agenda and in *constituency building* through providing a common platform and meeting opportunities.

The MNCH Partnership demonstrates another benefit which is in *strengthening accountability*. The UN Global Strategy 'Every woman, every child' differs from many WHO

programs in that a strong emphasis on accountability was built into it from the start, including accountability of donors for their commitments, accountability of intergovernmental organisations such as WHO, and most importantly the accountability of countries for implementing agreed reforms.

The role of the PMNCH in supporting accountability in relation to Every Women was shared with the Expert Review Group. It is significant that under the new arrangements the accountability function will be unified with the new 'Independent Accountability Panel' being established under the new (UN) Global Strategy for Women's, Children's and Adolescents' Health. The civil society member and partners in the PMNCH will still have an important role in applying leverage to drive implementation based on the findings and reports of the Independent Accountability Panel.

It is evident that the GHWA has been somewhat weaker in terms of supporting accountability in relation to the Code and the various WHA resolutions on HRH. It appears that the GHWA will be replaced by a more informal network managed by the Secretariat. It is possible that bringing the networking function more closely into the ambit of the Secretariat will further weaken the accountability function of the network.

Given the resistance of WHA Member States to any form of peer state accountability and the repeated mantra of MS sovereignty it appears that the partnership form may have advantages in that it distances the advocacy and potential criticism from the Secretariat. Civil society at the national level has a powerful role to play in holding national and subnational governments accountable for implementing public health principles endorsed through the WHA but WHO's regional and country offices face significant constraints in terms of their relationships with civil society locally. Partnerships can help to strengthen the local constituencies for public health and in doing so strengthen the accountability of governments.

However, partnerships can also undermine the sovereignty of the World Health Assembly if the partnership is dominated by a particular clique of donor states and/ or private sector entities with commercial interests in the directions that health policies take. This risk was exposed clearly in the case of IMPACT (see [Shashikant 2010](#)). See also our comments in relation to [Item 6.5](#) at this EB and WHO's close relationship with the roads lobby through the FIA.

Where the interests of certain member states and commercial sectors run counter to the commitments of the WHA there is a risk that 'partnerships' become platforms for caucusing and strategising in the pursuit of vested interests. Clearly WHO should not endorse or legitimise such 'partnerships' through hosting or membership.

It is obvious that hosted partnerships such as the GHWA and the PMNCH also include members and partners who have specific interests which are not always fully aligned with the policy directions mandated through the WHA. However, such conflicts of interest can be managed within an engaged policy community with transparency, and appropriate safeguards.

The risk is heightened when particular players have much greater power than others, either through finance or access to knowledge and technologies. This applies particularly to partnerships which are dominated by donors and by rich northern universities.

Donor funding of partnership programmes is part of a larger problem; namely the donor chokehold over WHO. The direct funding of partnership programmes while refusing to untie funds to WHO and refusing to increase assessed contributions is part and parcel of donor control and the disempowerment of the governing bodies.

The funding of the PMNCH to produce 'knowledge summaries' may be an illustration of this. The knowledge summaries appear to be informative, reliable and strategic but this kind of knowledge brokerage is one of the core functions of WHO. There is no reason why WHO itself should not be doing this work.

[EB138/47](#) and the two more focused reviews appear to fulfill the letter of the original EB decision ([EB132\(10\)](#)) but they are not very critical in terms of the kinds of issues canvassed above. They appear to have been written by people closely associated with the hosted partnerships.

GHWA

The GHWA is closing down. It seems it will be replaced by some kind of HRH network managed directly by WHO. Presumably the new 'network' will have a continuing capacity for advocacy and constituency building; in view of the new global strategy on HRH such advocacy and constituency building will be critically important.

However, it will be particularly important to ensure that the accountability function of the new global strategy is significantly strengthened (for example in relation to the implementation of the Code) .

In developing the accountability function for the new HRH network there is much to learn from the experience of the Global Strategy for Women's, Newborn, Children's and Adolescent's Health.

PMNCH

The PMNCH has a new Global Strategy and WHO is developing a new operational plan under the strategy (see [Item 7.3](#) on this agenda).

It will be important to build on the work that the Partnership has done with respect to accountability. While the functions of tracking, and evaluation of implementation will be vested in the new Independent Accountability Panel there will be a continuing need for advocacy, publicity and constituency building at the country level to drive implementation.

It is not clear whether the Partnership will continue to produce knowledge summaries. These summaries were positively commented upon in the 2013 Evaluation. Nonetheless, this function would clearly belong to the WHO Secretariat if WHO was properly funded.

13.1 HR Annual Report

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In focus

[EB138/51](#) provides an update on the implementation of the Organization-wide human resources strategy, in particular:

- the global mobility scheme (involving professional staff and a distinction between rotational and non-rotational positions);
- gender balance;
- geographic balance;
- staff costs;
- amendments to staff rules ([see](#)).

[EB138/51 Add.1](#) reports on a review and reform of the system for the nomination, selection and training of WHO country representatives.

Note that the PBAC will be considering a report ([EBPBAC23/2](#)) on WHO's internship programme. The PBAC conclusions will be reported to the EB in the PBAC report.

Background

The [revised HR Strategy](#) was noted by the EB134 in Jan 2014. Revision was necessary in order to align HR policies with the requirements of the WHO Reform.

Notable features of the new strategy, as reported in [EB136/45](#), include the abolition of continuing appointments, greater encouragement for staff mobility and the move to more uniform HR policies and practices across the Organisation.

For more background see the [Secretariat Budget Page](#).

PHM comment

In relation to

Global mobility

The move to mandatory rotation (in the context of the move away from permanent appointment) will need to be carefully evaluated for unintended adverse consequences.

The principle of declaring certain positions non-rotatory makes sense although in many organisations it is the person rather than the position who is of unique value in particular settings.

Geographical balance

Para 13 of EB138/51 states that 32% of MS are under represented in the international professional staff category. The para refers to more detailed tables but as of early January the link was non functional.

[Fig 6 in WHA67/47](#) illustrates the under and over representation as of 2012. Delegates should recall that the formula for determining that a country has the right number of professional staff (Resolution A56.35) gives great weight to the financial contribution of the country. Thus in 2012 the USA had more of its citizens in professional and higher categories than any other country but were still recorded as being under represented.

Nomination, selection and training of WHO Country Representatives

Sensible reforms.

Interns and junior professional officers: exclusion of young people from L&MICs

Interns constitute around 16% of the human resources upon which WHO depends nor junior professional officers ([here](#)). Both interns and junior professional officers represent very promising pathways towards recruitment to formal employment.

However, in both cases, these pathways effectively exclude young people from low and middle income countries. Access to internships requires independent funding. Access to JPO opportunities appears to be completely restricted to Europeans. Given the commitment to 'diversity' in the Strategy this exclusion is not appropriate. PHM urges the inclusion in the HR Strategy provision for scholarships to support young people from L&MICs to access intern and JPO opportunities.

The Secretariat report ([PBAC23/2](#)) acknowledges the problem with respect to interns but simply referring candidates to lists of other scholarships is inadequate.

13.2 Report of International Civil Service Commission

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- [Notes of discussion at EB138](#)

In focus

[EB138/52](#) contains details of the deliberations and recommendations of the International Civil Service Commission for the year 2015, including those relating to the comprehensive review of the common system compensation package. The report provides a link to the [forty-first annual report](#) of the International Civil Service Commission.

13.3 Amendments to the Staff Regulations and Staff Rules

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- [In focus](#)
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- [PHM comment](#)
- [Notes of discussion at EB138](#)

In focus

Secretariat document: [EB138/54](#) seeks confirmation by the Board of amendments to the Staff Rules and Regulations made by the DG:

- amendments necessary because of salary decisions applying across the UN system;
- amendment dealing with financial responsibility, classification review, and recruitment;
- amendments necessary for the WHO internal justice policy reforms.

Background

See Annex 1.

14.1 Expert committees and study groups

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In focus

The report ([EB138/53](#)) on meetings of expert committees and study groups, reports on only one Expert Committee, namely the 20th meeting of the Expert Committee on the Selection and Use of Essential Medicines considering the role and decision criteria for the 19th WHO Model List of Essential Medicines and the 5th WHO Model List of Essential Medicines for Children.

In a second report ([EB138/53 Add.1](#)), the Secretariat provides details of both meetings and membership of expert committees that met in 2015.

Background

See the [EML selection web page](#) for useful information and expert commentary.