



WHO Watch Report on the 65th World Health Assembly

Introduction

WHO Watch is pleased to present this report on the debates and decisions taken at the 65th World Health Assembly and 131st Executive Board meeting.

WHO Watch is a project of the People's Health Movement, undertaken in association with a range of collaborating organisations (for further information about WHO Watch see www.ghwatch.org/who-watch). It is part of a broader initiative directed at democratising global health governance.

The purpose of this report is to share more widely within PHM and related networks our understanding of the state of play in global health, as seen through the window of WHO's governing bodies. Our hope is that the availability of this information might help to stoke mobilisation and advocacy towards Health For All, including action around the items documented below.

This report covers many but, owing to resource limitations, it was not possible to include report and comment on all of the issues discussed and debates engaged during the WHA and the EB. This report is taken from more detailed documentation to be found on (or linked from) the [WHO Watch website](#), more specifically [WHO Watch's WHA65](#) website. Further information is available on the [WHO's Governing Bodies website](#).

We gratefully acknowledge the support of the many colleagues who have supported this watch in many different ways. We salute also our colleagues from previous watches. We apologise in advance for errors of fact or judgement and would welcome comments and suggestions. Please write to who-watch@phmovement.org.

We look forward to working with you for Health for All, Now!

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12. WHO Reform

Issues before the Assembly

WHO ‘reform’ has been the subject of vigorous debate within the WHO Secretariat, among staff, among member states (MS) and among a range of non-government organisations.

The problem at the heart of the ‘reform’ is financial. The WHO has become very dependent on donor funding to support its programs and activities. Less than 20% of the expenditure budget comes from ‘assessed contributions’ (mandatory contributions based on an agreed formula); the rest comes from rich member states, other intergovernmental organisations, global health initiatives (such as the Global Fund) and philanthropies, notably the Gates Foundation. This has created a serious tension between the agenda of the MS and that of the donors. It has also contributed to dysfunctional administrative and managerial procedures, in part because of the pressures on clusters and regions to embark on parallel and competitive fund raising; in effect selling their ‘products’ to the donors. The previous debates and documents regarding WHO Reform are described and documented at www.ghwatch.org/who-watch/whoreform.

Three papers were provided to the member states (MS) for this Assembly: first a ‘consolidated report’ on the progress with respect to the WHO Reform process; second, an

outline draft global program of work (GPW) 2013-2019; and third the report of the ‘Stage I Evaluation’ commissioned as part of the WHO Reform process.

The [Consolidated Report](#) (CR) on decision making and progress with respect to WHO Reform (A65/5) was structured around 16 ‘decision points’ for decision by the Assembly. These decision points dealt with the categorisation of WHO’s management and budget lines, the governance of WHO, alignment between the work of Headquarters (HQ), regional offices and country offices, harmonisation of procedures across regions, streamlined decision making, engagement with various stakeholders, staffing policy and practice, fund raising for WHO, accountability, and evaluation.

Also provided was a draft outline of the Global Program of Work (GPW) 2014-19 ([Document A65/5 Add.1](#)). A more detailed version of this will be considered by the regional committees in late 2012; a revised version will go to the Program, Budget and Administration Committee (PBAC) of the Executive Board (EB) in December 2012; then to the EB in Jan 2013 and for final adoption by the Assembly in May 2013.

Finally the Assembly had before it the report of what was known as the Stage I Evaluation which was part of the WHO Reform Program (ref. to [A65/5Add. 2](#)). The Assembly is invited to note the findings of the ([Evaluation Report of Stage 1](#)) and recommendations, as well as the roadmap for the Stage II evaluation.

Report of debate on WHO reform at WHA65

Much of the attention of the Committee was taken up by a long running debate over the proposed five ‘categories’ which figure centrally in the [draft outline GPW](#).

(Previously WHO has used three documents to shape its planning and budgeting: the GPW, the Medium Term Strategic Plan and the biennial Program Budget. Resource allocation was based on 13 strategic objectives, corresponding broadly to the organisational ‘clusters’.

Earlier in the reform process it was decided to do away with the Medium Term Strategic Plan and work only with the GPW (2013-19) and the PB(2013-14) and to reduce the number of high level budgeting and planning categories. In a MS consultation earlier in 2012 it was decided to reduce the number of categories to five: communicable diseases, non-communicable diseases, health systems, emergencies and corporate services.)

Paraguay, Bolivia, Brazil and Colombia argued that there should be a new category, perhaps called Social Determinants or Sustainable Development. Clearly UNASUR had prepared for a campaign around the effective absence of SDH from the draft outline GPW.

However, Turkey, Japan, Bahrain and China all stated that they agreed with the five proposed categories. USA and France were more aggressive stating that “there is no question of going back to the old discussion”.

Canada, UK and Switzerland took a more nuanced approach. They argued that SDH was a cross cutting issue and that the GPW needed to show somehow how the various cross cutting issues would be planned, budgeted and accounted for. Social determinants of health are relevant to all of the ‘categories’. Switzerland proposed staying with the five categories recognising a cross cutting issue on SDH called health determinants and equity. Canada

pointed out that the management of cross cutting issues and the ‘priority topics’ need to be properly accounted for in the GPW and PB.

In an observer’s statement the Geneva based NGO Forum on Health also pointed out that [A65/5](#) is not clear on how the right to health will be achieved in relation to other instruments. It needs to be mainstreamed into all of WHO’s work and priorities. The Right to Health needs to be integrated into the draft 12th GPW.

There were several comments on the draft GPW itself. Ecuador noted the need for more clarity in the GPW. Norway and Denmark (speaking on behalf of the EU) commended the Secretariat for the outline GPW.

Paraguay (speaking for UNASUR) and Switzerland felt that the GPW was too strongly medical rather than health focused.

Cuba and Germany commented that work on priority setting had not yet been reported: The work on priority setting has still to take place.

Responding, the Director General (DG) explained that the draft priorities list will be based on a review of country cooperation strategies (CCS) in consultation with the Global Policy Group.

Several states spoke about issues which they believed should be included as priorities in the new PB. Saudi Arabia argued that visual impairment should be a priority. Mongolia argued that zoonotic diseases should be prioritised under the communicable disease category. and argued for environmental determinants of health to be included as a new category. El Salvador asked for priority to go to environmental and occupational toxins under the NCDs category.

Sweden, Norway, Japan, Lithuania and Egypt all spoke about the proposed financing dialogue. (This is the latest term used to describe how WHO’s budget negotiations with its donors will be structured under the new reforms. This has moved from a ‘World Health Forum’ (proposed by the DG in early 2011), to a pledging conference (in late 2011) and now a ‘financing dialogue’. It is proposed that the financing dialogue will take place after the EB in January and before the WHA in May.)

Most MS were cautious about the financing dialogue, emphasising that the governing bodies have to remain in charge of the WHO agenda. Sweden emphasised the need for transparency. Norway emphasised that the purpose of the financing dialogue must be to finance the priorities set by the WHA. Lithuania (on behalf of the EU) stated that the EU will continue to contribute to WHO in line with priority settings A successful financing mechanism needs WHO to be mandated to say no to funds that are not in line with WHO priorities.

Ecuador, speaking on behalf of UNASUR emphasised the need for predictable financing and regretted that it had been so hard to get agreement on increased assessed contributions (and thereby decreasing reliance on voluntary (donor) contributions). Thailand commented that we have had zero growth of assessed contribution for two decades. “We should pay more for this organization. It’s a pity that the document doesn’t challenge MS on this issue”. In an observer’s statement Oxfam called for a fundamental shift in how WHO is financed: increase assessed contributions.

When the discussion moved to ‘managerial reforms’ Switzerland spoke about the need for changes to the rules to limit number of agenda items accepted for the WHA.

Indonesia supported the initiatives for closer alignment between the agendas and programs of the regions and regional committees and the Secretariat Headquarters and global governing bodies.

New Zealand supported the proposed harmonisation across regional committees.

Ecuador spoke about the management of conflict of interest in the organisation. They commented that it is important but hard.

Estonia (on behalf of the EU) spoke in support of the closer involvement of civil society and NGOs in the work of WHO but called for clarification on the different categories and the areas of engagement and called for an explicit policy paper on the relations of the WHO with different categories of stakeholders.

In observers’ statements Consumers International & IBFAN stated that improvement in WHO’s relationship with public-interest NGOs is needed. Such improvement may even require restricting engagement with actors promoting commercial interests. Consultations on this matter should build on the analysis and recommendations of the 2001-02 [WHO Civil Society Initiative](#) and a thorough review of current practice regarding civil society¹.

After this general round of comments the Committee focused on Priority Setting.

The discussion on priority setting and on the Draft Twelfth General Programme of Work (GPW 12) started with Brazil stating that they were not ready to endorse the Chair’s summary of the February meeting of MS. Brazil affirmed that more clarification and more discussion was needed since the document does not capture all countries’ positions. UNASUR backed Brazil and went further suggesting to introduce a sixth category on social determinants of health (SDH). Some countries expressed their concern on re-opening an issue that was already discussed during the February meeting while Switzerland affirmed that SDH should rather be a horizontal bar cutting across all categories.

Many countries aligned themselves either with UNASUR (Cuba, South Africa) or with Switzerland (China, EU, Lebanon, Botswana, Senegal).

The DG recognized that more work is to be done on priorities and that the next version of the GPW 12 will provide more details. She sought to reassure Member States saying that either as a cross-cutting issue or as a priority, funds need to be provided for SDH. She also stated “if it is an independent category, you may get a bit more visibility, but that’s all. The categories will not get money, but the priorities will get money”.

Thailand, trying to find a compromise, suggested to rename the third category as ‘Social Determinants of Health and Health Promotion through the Lifecourse’. However, no consensus was reached on this suggestion.

¹. To enter into ‘official relations’ with WHO an organisation needs to demonstrate that it is actively collaborating with WHO and submit a work plan for such collaboration for the next period. There is no assumption that civil society might have a right to observe WHO deliberations or the capacity to contribute to those deliberations or that WHO should be in anyway accountable to civil society.

At the end of the debate the Assembly adopted a [Decision on WHO Reform](#) which provided further guidance to the Secretariat in relation to programmatic, governance and managerial reforms. On the critical issues of priority setting and assessed contributions the decision is silent.

PHM Comment on the WHO reform items prior to the debate

Comments on the Consolidated Report

In comments circulated before the debate PHM commented on some of the Decision Points included in the DG's 'consolidated report'.

In relation to the proposals for re-scheduling the meetings of the governing bodies PHM commented that the proposals sought to formalise the reality that the donors have been given control of WHO's agenda. All of the suggested sequences would have the EB prepare a draft program budget which then goes directly to the donors (the financing dialogue) and only after the donors have decided what to fund does it come to the Assembly. It is hard to avoid the image of the Secretariat auctioning its programs to the donors and then presenting the assembly with a *fait accompli* with respect to the program budget.

The DG had brought forth a number of initiatives and proposals for harmonising (or standardising) the ways in which the regions work. PHM expressed concern about the passage in para. 33 which would allow Regional Committees to invite the observers that "they wish to attend". If accreditation follows a known official procedure, then there is no place for picking and choosing which organisations get accredited. There is a pressing need to reform the procedures, rules and protocols for the participation of civil society in global and regional governing bodies.

WHO is a member state body and this is part of its strength. However, there is untapped value to be gained from building a more collaborative relationship with public interest civil society organisations at the country, regional and global levels.

Closer involvement of civil society as observers in RCs would strengthen the accountability of regional committees and bring fresh perspectives for discussion. Civil society collaboration would add value to program implementation as well as policy making and accountability.

Under the heading of 'streamlining decision-making in governing body meetings' the DG refers to a number of proposals for tighter discipline on late resolutions; for new mechanisms to vet resolutions coming to the governing bodies and for arbitrary limits on repeat progress reports. PHM supported the need for more discipline in managing late resolutions submitted to the WHA but opposed the proposal that Officers of the Board might curtail the right of MSs to propose resolutions to the governing bodies. There may be merit in reflecting on earlier resolutions and seeking coherence between resolutions on related subjects but this should not restrict the sovereign right of MS to table resolutions on matters they deem important.

PHM cautioned against the seemingly increasing trend of using summaries of discussions developed by Chairs of intergovernmental meetings. The Chairman's summaries under recommendation in para. 43 have no legal status and are not binding documents. They are not decisions, and do not reflect the intergovernmental nature, or capture the diverse

opinions, of the meetings they summarise. They also face the difficulty of implementation, hence accountability, because of lack of consensus (necessary for any intergovernmentally agreed text).

Under the heading ‘effective engagement with other stakeholders’ the DG had reviewed the different kinds of partnerships and relationships that WHO engages in, including: with other intergovernmental bodies, private sector organisations and non-government organisations. PHM appreciated the commitment to review WHO’s relationship with NGOs at global, regional and country levels and the recognition of the importance of discerning clearly between different types of NGOs engaging with WHO.

PHM appreciated also the focus on clearer protocols for managing conflicts of interest of various kinds and look forward to finalisation and implementation. We urge an explicit commitment to excluding private sector entities from direct involvement in policy-formation and norm-setting activities.

Under the heading, ‘strengthening technical support to Member States’ the DG articulated a commitment to strengthening technical and policy support to member states and reports on a number of initiatives to this end. PHM commended this commitment and the progress which has been made.

PHM appreciated that the value of including civil society in policy dialogue at the country level had been recognised and the new emphasis on the role of the WHO country office in promoting such dialogue. Community based NGOs can contribute to policy formation and to constituency development for policy implementation.

PHM noted the commitment to refine the role of country cooperation strategies (CCS) in shaping the WHO work program and in particular the recognition that the objectives articulated in the CCS must be funded. PHM calls for greater accountability and transparency with respect to CCSs.

Under the heading ‘staffing policy and practice’ the DG reported on a number of initiatives designed to promote improved staff performance, and a more flexible mobile workforce. PHM noted that WHO works in a complex and shifting environment and getting staffing policies and practices right is of critical importance for the organisation and for global health. We recognised that there is a range of debates over regional representation, recruitment policies, types of employment and mobility. There are clear risks associated with the current move to short term contracts, greater mobility and contracting out. If these options have been subject to robust analysis and evaluation this work should be published. It is difficult for member states to endorse a particular staffing strategy in the absence detailed description and evaluation of current practice and evaluation of options for policy reform.

In relation to the proposed financing dialogue PHM noted that the DG’s comments on results based financing and the financing dialogue presume the continued freeze on increases in assessed contributions. This freeze is disabling WHO. PHM urges MS to re-open consideration of a substantial increase in assessed contributions. We urge donors to convert earmarked contributions to untied grants.

The DG has committed to ‘results-based budgeting and resource allocation’ based on the new (12th) general program of work (GPW). PHM commented that the outline GPW

which has been published ([A65/5 Add1](#)) is completely silent with respect to planning for, budgeting for and accountability for cross-cutting issues such as the right to health, trade and health, gender equity and the social determinants of health.

The discussion of the scheduling of governing body meetings and the timing of the financing dialogue highlights the power that donors will have over the Program Budget before it is adopted by the Assembly. This is not compatible with the claim that WHO is a MS driven organisation.

PHM Comment on the Draft Outline GPW

The ‘cross-cutting’ issues (in particular, social determinants, trade relations, the right to health, primary health care, gender equity) are completely neglected in this GPW and in the DG’s Consolidated Report.

PHM recognises the logic of adopting a particular set of categories for budgeting purposes. Such categories are always going to be arbitrary and carry the risk of privileging those categories as against alternative possible categorisations.

A more coherent and integrated GPW requires effective planning, budgeting, evaluation and accountability mechanisms for the cross cutting issues as well as the ‘categories’ which are adopted as line items for budget purposes.

These cross cutting issues include social determinants, trade, the right to health, primary health care and gender equity. In this GPW some of these issues are identified as over-arching principles (PHC and trade are completely absent) but there is nothing in the GPW or the DG’s Consolidated Report about strategic planning and accountability in relation to issues.

The achievement of the right to health and gender equity for example can only be assessed in relation to what is happening on the ground in countries. There should be robust reporting from country and regional offices on the achievement of these objectives.

WHO’s evaluation framework needs to make provision for meaningful evaluation in relation to all of the agreed cross cutting issues, at the global, regional and country levels including targets and milestones.

The planning function is also vulnerable in relation to the cross cutting issues. The draft GPW identifies Preparedness, Surveillance and Response as one of the five categories. The risk is that the cross cutting issues of human rights, the role of primary health care, gender issues and social determinants in epidemics and disasters will be neglected. Disasters, including ‘natural’ disasters always impact more devastatingly on the poor who suffer lack of basic housing and sanitation.

The [Rio Declaration on Social Determinants of Health](#) has called for monitoring and accountability mechanisms in relation to the SDH. (See also resolution [WHA62.14 on Reducing health inequities through action on the social determinants of health](#).) The WHO EB endorsed the Rio Declaration in its 130th session last January, and recommended to the 65th WHA a draft resolution text with that very content ([EB130.R11](#)).

There is no reference in the GPW to the issues of planning, evaluation and accountability in relation to SDH, at the time when MS are about to consider a draft resolution on the matter!

PHM Comment on the Stage I External Evaluation Report

PHM noted that the External Evaluator failed to address its terms of reference.

The Evaluator was asked to review the existing information with respect to finance, staffing and internal governance. This was not done.

Instead the team reported on a very positive evaluation of the WHO Reform Program as implemented so far (see [Stage I Evaluation Report](#), from page 57). This they were not asked to do; at least, not by the Executive Board. The evaluator has created a new set of terms of reference for the evaluation which bear no relationship to those adopted by the EB (see page 9).

PHM comment on WHO Reform following the debate

The outstanding issue at the heart of the current WHO reform program is the failure of the MS to increase the level of assessed contributions and the consequent exposure of the Organisation to the dictates of the donors. WHO is not in control of its own agenda.

A small number of MS will speak these truths publicly. Many more will say so privately. Meanwhile the donor states are happy to continue to exercise donor control and the middle income countries, especially the BRICS, who would be required to significantly increase their contributions if ACs were increased, seem to be happy for the extra burden to remain with the high income countries, even if it is disabling WHO. The LDCs remain silent publicly for fear of reprisals in bilateral aid relations.

The current solution is the ‘financing dialogue’ which has been wrapped in various assurances including the expectation (from some MS) that the DG will refuse donations which are not in line with the Organisation’s priorities. While there is much uncertainty about how the financing dialogue will work and the kinds of outcomes it might achieve, it could not be worse than the present arrangements which are much less transparent with much looser links to the Organisation’s priorities. Whether it will be significantly better is a matter for varying degrees of scepticism.

Critical to the regime being developed is the articulation of clear priorities. This has been an article of faith among all of the MS who have been driving the reform process but there have been no operational decisions about how to derive priorities. The DG announced during the WHA that she will work with the regional directors to derive Organisation-wide priorities from the country cooperation strategies (CCS). There is a certain elegance to this concept if indeed the CCSs capture the local manifestations of the global barriers to HFA. However we need to ask how validly the CCSs reflect the country specific priorities (as opposed to expectations of what WHO can deliver) and how easily country priorities can be extrapolated to global priorities.

The DG promises that the outcome of her prioritisation process will produce a first draft priorities list only and that MS will have the final say. However, according to the new annual schedule of meetings the draft PB to be adopted at the EB in Jan 2013 will provide the

basis for the financing dialogue in the first quarter of 2013 so the priorities offered to donors will be those developed by the DG as modified by the EB before the methodology and outcomes have been considered by the WHA.

The WHA will be asked to consider and confirm the GPW and PB in May 2013 but only after the priorities adopted by the DG and EB have been offered to the donors. Since both the DG and the EB members know very well what sorts of projects the donors would like to fund, the whole process is rather compromised.

The relative roles of the DG and the MS in decision making is problematic in other respects including the proposed restrictions on the right of MS to submit resolutions to the EB and the rising role of Chairpersons' Summaries as a way of drawing conclusions from inconclusive debates. Meanwhile new HR policies and practices, critical parts of the reform program are being put in place with very little participation by MS. The Stage I Evaluation Report was supposed to assemble the available information needed to inform decision making regarding the reform process but was diverted into a quite unusual evaluation of the reform process to date (with the effect that the information required remain unassembled and the MS receive a very positive evaluation of the reform program which they had not requested). It is understood that some of the critical documents that the Evaluator accessed were unable to be referred to in the report because the Secretariat had agreed to non-disclosure provisions.

Another critical area of the new arrangements which will have to be resolved without WHA consideration is the handling of the 'cross cutting' issues, including social determinants of health, the right to health, gender equity and primary health care. The DG has declared that she personally will 'look after' these areas but she has offered no methodologies for assuring systematic planning and policy making, budgeting, accountability and profiling of these areas. It appears that such methodologies are still to be developed.

The consequence of these decisions (and non-decisions) is that WHO's agenda will continue to be determined by rich MS, intergovernmental donors and private philanthropies. Most of these players have quite specific interests (and perspectives) which they are actively promoting through their donations to the WHO. These interests, in many respects, run counter to the interests of most of the MS.

MS representatives have a moral obligation to speak out against these arrangements. There is an urgent need for civil society action to save WHO from itself.

Priorities for civil society advocacy in relation to WHO Reform

From a PHM perspective generally, the priority themes for advocacy in relation to WHO Reform include the following:

- make member states accountable to their domestic polity for how they speak and vote in WHO and (for the donor states) for their financing policies
- urge member states to push strongly for an increase in assessed contributions and the conversion of earmarked funds to untied donations
- highlight the distortions in policies and programs consequent upon the donor choke-hold on WHO's agenda (eg support for the industry-sponsored IMPACT while completely failing to fund rational use of medicines; talking

- ‘partnerships’ with the food industry while progress on the trade and health agenda has completely stalled);
- monitor the continuing managerial reform process against WHO’s constitutional mandate
- encourage the Secretariat and MS to work more collaboratively with civil society at the global, regional and country levels including more flexible arrangements for participation in governing body discussions

Clearly the advocacy priorities and strategies regarding WHO reform will be different for PHM circles in different countries. In the donor countries the priority might be liaison with ministries of health and foreign aid to advocate for increased assessed contributions and conversion of earmarked to untied donations. One strategy for making MS delegations more accountable for their contribution to WHO decision making is to call for parliamentary hearings. In the BRICS there might be scope for discussions about the BRICS increasing their contributions to WHO. In other L&MICs the priority might be more to do with how the WHO country office works and how it works with civil society.

WHO Watch is keen to strengthen our presence at regional committee meetings and is looking for support in PHM country circles to achieve this. ‘Watching’ at the regional level (actually watching, engagement and advocacy) involves working on the regional committee agendas before meetings, working with ministries about these items in the lead up to the meetings and participating as observers at the meetings.

13.1 The prevention and control of NCDs

Issues before the Assembly

In 2011 two high levels meetings on NCDs were held: a [Global Ministerial Conference on Healthy lifestyles and NCDs in Moscow in April 2011](#); and [High Level Meeting of the UN General Assembly on Prevention and Control of NCDs](#) in New York in September 2011. The World Health Assembly was invited to ‘note’ the outcomes on these two meetings [A65/6](#) and provide further guidance.

The [Political Declaration on NCDs](#) that was endorsed at the New York HLM called on WHO to present, before the end of 2012:

- a comprehensive global monitoring framework, including a set of indicators, capable of application across regional and country settings, including through multisectoral processes, to monitor trends and to assess progress made in the implementation of national strategies and plans on NCDs;
- recommendations for a set of voluntary global targets for the prevention and control of NCDs and options for strengthening and facilitating multi-sectoral actions for the prevention and control of NCDs through partnership.

In relation to these items, the WHO Secretariat developed documents [A65/6](#), [A65/6 Add.1](#), and [A65/7](#), and the Health Assembly was invited to note the reports, to share views and to provide further guidance. In addition, the WHA was invited to note reports on the implementation of the Global NCDs Strategy ([A65/9](#)) and Action Plan ([A65/8](#)). Finally the

Assembly was invited to consider a draft resolution ([EB130/R7](#)) adopted by the EB in January. See [WHO Watch Comment on this item at EB130](#)

The Assembly was invited to note a paper on ‘options and a timeline for strengthening and facilitating multisectoral action for the prevention and control of non communicable diseases through partnerships (Document [A65/7](#)).

This item arose from the [global strategy for the prevention and control of noncommunicable diseases and the action plan](#). See Document [A65/8](#) for the Secretariat’s report on the implementation of the GSP&CNCDs. See also the full [GSP&CNCDs](#) (from page 82). See [WHO Watch comment on this item at EB130](#)

Report of debate around NCDs

The Assembly received wide inputs from Member States around the proposed global voluntary targets and MS proposed the inclusion of additional targets including targets on mortality, raised blood pressure, tobacco, salt and physical activity, obesity, fat intake, alcohol, and health systems (access to essential medicines for NCDs).

- India called for the inclusion of suicide rates as a feasible indicator for mental disorders;
- El Salvador called for an indicator on renal failure;
- Tanzania called for targets for alcohol abuse and gender based violence; and
- Mongolia called for the inclusion of HPV vaccinations as an indicator, as well as vaccinations against some cancers.

Philippines called for WHO to strike efficient balance between prevention and treatment; whilst Thailand proposed better access to medicines and action on indoor pollution and child obesity. In addition, Thailand and Norway called for broader approach (rather than solely focusing on access to medicines) as well as actions to address conflict of interest.

Bangladesh and the Member States from the African Region called for attention to the double-burden of communicable and non-communicable diseases faced by many countries.

On the other hand, the International Alliance of Patients Organisations (IAPO) said the targets are too focused on prevention and not enough on treatment. Therefore, IAPO proposed including access to treatment as a target. (IAPO is a federation of patients groups which receives extensive financial support from the pharmaceutical industry.)

[A statement by PHM and Churches Action for Health](#) called for more commitment from Member States and WHO to work on international trade agreements in relation to NCDs. On the multi-stakeholder partnerships, PHM called for transparency and integrity at global and national level to be observed in these relationships.

A number of member states and observers (such as the International Federation of the Red Cross and Red Crescent, and World Heart Federation) called for Member States to commit to including NCDs in the Rio+20 and a post-MDGs agenda.

Health Action International (HAI) urged member states to properly address access to effective generic medicines and ensure availability and affordability of medicines.

A draft decision proposed by the delegations of Australia, Barbados, Brazil, Norway, Russian Federation, Switzerland, Thailand and USA was debated but members could not reach immediate agreement. Therefore, the discussion was suspended and an informal drafting group set up to work on the proposed resolution. The group had difficulty achieving consensus and in the end proposed that in recognition of the fact that setting of targets is both technical and political, there is the need for regional committees and other regional constituencies to be involved in the target setting process. A range of indicators were brought forward and discussed. There was sufficient agreement that the mortality target should be adopted by this WHA in order to report to the UN General Assembly in September.

Finally the Assembly adopted a [Decision](#) on Prevention and control of non communicable diseases: follow-up to the High level meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable diseases (in Second Report of Committee A)

PHM comment

Pre-debate

In the lead up to the Assembly PHM circulated the following commentary on the issues before the Assembly regarding NCDs.

While there is rhetorical recognition of the larger scale issues of trade and industry practices in this report it seems there is very little action on this front. The implications of investor state dispute settlement (ISDS) provisions for tobacco control and food regulation and the implications of ever tighter IP protection for affordable access to medicines are self evident. But WHO has completely avoided them. Furthermore, the significance of neoliberal economic policies in widening inequalities has not been addressed.

WHA resolution, [WHA59.26](#) on international trade and health highlights a number of crucial issues in relation to trade and health, and the WHO's role in capacity strengthening in this area. Global level action and coordination is needed to address some of the trade related determinants of NCDs (WTO, Codex), including the introduction of an international code on marketing of unhealthy foods, and drinks (including alcohol) to children. Because the factors that shape NCDs lie outside the reach of health policy, the most health gains in terms of prevention will be made by influencing policies in domains such as trade, food and pharmaceutical production, agriculture, urban development, and taxation policies. Such approach to preventing NCDs should go beyond education, housing and agriculture to also include the structural determinants of health. We urge Member States to explicitly recognize the role of trade policies in the spread of NCD risk factors and commit to ensure that future trade treaties do not increase such risks.

A continuing concern in relation to NCDs is the sustained focus on partnerships and engaging in multi-sector consultations. The private sector – whilst a very important actor for policy implementation – appears to be embedded throughout the processes . This is an important concern for food and nutrition, but also alcohol. The continued failure by WHO to distinguish between public interest NGOs (PINGOs) and Business interest NGOs (BINGOs) compounds this issue. The UN High Level Meeting “civil society hearing” which included representatives from the food and alcohol industry was a case in point.

The WHO Director General, in her report to the WHA on progress on WHO Reform and governance ([A65/5](#)), states that member states have agreed to the following principle: “the development of norms, standards, policies and strategies, which lies at the heart of WHO’s work, must continue to be based on the systematic use of evidence and protected from influence by any form of vested interest.” It is important for WHO to adopt this principle in determining future policy and governance and action on NCDs.

Also in keeping with recommendations made in the WHO reform paper ([A65/5](#)): WHO should also develop a framework to guide interactions with all stakeholders on the prevention and control of NCDs, at both the national and global levels.

WHO should provide technical support and expert advice to member states on the implementation of fiscal, legislative and regulatory measures to improve food and nutrition. This should involve technical support to finance ministries on the administration of national food tax and regulatory systems and administration, as well as the production of manuals and toolkits.

[PHM statement to Committee A](#)

PHM comment post debate

NCDs constitute a huge and growing burden of disease.

Their causation can be understood in different ways: from genes (appetites for salt, sugar and fat), to behaviour (smoking and diet), to social determinants (market choices, urban design). The current direction in which WHO is moving is likely to lead to a focus on biomedical and behavioural causes to the exclusion of structural causes. In view of the close association of NCDs prevalence with socio-economic inequality, relying solely on the pharmaceutical and behavioural strategies reflects a discounting of the equity and social justice dimensions of the public health challenge.

In the Moscow conference and the NY Summit the focus has been on the leading risk factors and associated behaviours. However, pharmaceutical and behavioural approaches without addressing the social determinants approach will be less effective and not sustainable. An effective strategy needs to be broadly based and to address the structural and environmental factors which shape those behaviours. Smoking is shaped by powerful marketing; diet is shaped by marketing and price relativities; inactivity is shaped by town planning.

Much of the policy commentary on NCDs is couched in the language of partnerships and multi-stakeholder intersectoral collaboration. This appears to mean collaboration with the food industry to promote more health oriented marketing and collaboration with town planners without confronting the urban land speculators who shape their decisions. This approach has the benefit of conflict avoidance but the disadvantage that it will not achieve structural change.

Like the tobacco industry the food industry, from farm to supermarket, is dominated by transnational corporations. A strategy which avoids the challenges of regulating transnational corporations is destined to fail. Engaging with trade negotiators is the first step to regulating transnational corporations. However, while WHO talks about multi-stakeholder strategies the US and Europe are spinning a web of ‘WTO plus’ trade agreements which are deliberately

structured to prevent the regulation of TNCs. One of the leading tools in this purpose is the principle of ‘investor protection’ through investor state dispute settlement. This allows transnational corporations to sue governments whose regulations have the effect of diminishing the value of their investment (most notoriously applied in the Phillip Morris suit against Australia’s plain packaging laws).

WHO’s donor countries have refrained from supporting WHO’s work on trade and health coherence as mandated by [WHO59.26](#). Indeed some of the main donors are the same countries which are driving investor protection provisions in trade agreements. The structured conflict of interest in the financing dialogue is blatant.

There is also a risk that the narrow focus on four specific diseases will contribute to a vertical disease focused approach to management rather than a more broadly based primary health care approach. The professional and institutional capabilities which are needed to care for patients with the four NCDs have much in common with a range of other chronic diseases. These include continuity of care, quality management, monitoring and follow up, effective links between primary and more specialised services and quality, safe, efficacious and affordable medications and devices. The management of NCDs should be progressed within a broadly based approach to health system strengthening, universal access and primary health care.

It is not clear what a new ‘platform’ for NCDs might look like; one scenario appears to involve a new ‘global fund’ for NCDs with funds mobilisation and disbursement focused on NCDs or more narrowly on pharmaceutical and behavioural prevention and on disease focused management.

The multi-stakeholder partnership approach needs to be approached carefully in relation to the transnational pharmaceutical corporations. Pharmaceutical approaches to prevention, management and cure have great potential for health gain and great potential for increasing profits and returns to executives and shareholders. Both with respect to rational drug use and affordable access to necessary medicines the interests of the large pharmaceutical corporations (and their host countries) diverge from those of public health. Most of the donor countries have chosen not to support WHO’s role in the rational use of medicines over the last three decades. Indeed the ceiling on assessed contributions was first imposed as a sanction against WHO for its work on essential drugs lists. In a time of financial crisis the export earnings of Big Pharma constitute a valuable contribution to the trade balance.

Reliance on the patent mechanism to incentivise drug development necessarily involves high prices under patent protection and as a consequence, inequitable barriers for poor people and poor countries seeking to access quality, safe and efficacious medicines. The three main solutions to this problem currently in operation are compulsory licensing, donor supply and differential pricing. Talk of an NCDs ‘platform’ suggests an approach to mobilising donor funds to support access to NCD medicines. The policy questions here are complex but WHO’s capacity to take an evidence based approach to these questions is compromised by the clear conflicts of interests around the policy positions taken by those donors who also host large transnational pharmaceutical corporations.

Determination of an appropriate policy, funding and regulatory regime to address the NCDs crisis does not lie with WHO alone. However, WHO has a responsibility to reach out to other sectors to explain the epidemiological and social justice dimensions and to offer evidence based analysis and options. Freeing WHO from donor hostage is a necessary condition for it to be able discharge this responsibility.

Themes for advocacy

From a PHM perspective generally the priority themes for advocacy in relation to NCDs include the following:

- oppose the inclusion of investor state dispute settlement provisions in trade agreements;
- push for new instruments to regulate TNCs at the domestic and international levels as part of creating an improved nutrition and food security environment;
- protect small farmers from exploitation by input companies and unfair competition from subsidised transnational agribusiness;
- ensure that food security and nutrition policies include a balanced approach to protein and energy as well as micronutrients;
- monitor the use of manufactured ready to use foods, advocating that their use is restricted to emergency settings;
- promote policies directed to affordable access to quality, safe and efficacious medications; promote the strengthening of drug regulatory agencies; promote the rational use of medicines.

Advocacy strategies

These are general advocacy priorities; clearly the priorities will vary widely between countries. However, there are some general strategies which PHM country circles may wish to consider:

- build collaborative relations across the many NGOs who are working on different aspects of these problems (trade, farming, seeds, food security, nutrition, labour conditions, human rights, etc);
- ensure that the NCDs debate remains closely linked with policy debate and action around health systems strengthening, primary health care, social determinants of health and WHO reform;
- develop collaborative engagement with the NCDs Alliance and its country level partners;
- undertake systematic assessment of the local situation and local priorities
- develop constructive engagement with government;

13.2 The global burden of mental disorders and the need for a comprehensive, coordinated response from health and social sectors at the country level

Issues before the Assembly

The Assembly was invited to note a report from the Secretariat on the global burden of mental disorders and the need for closer coordination between health and social care ([A65/10](#)) and to consider a resolution forwarded by the EB (resolution [EB130.R8](#)).

Debate

At its 130th session in January 2012, the Executive Board adopted a draft resolution (EB130.R8) presented by India and cosponsored by US and Switzerland. The WHA was invited to consider it and to note a report from the Secretariat on the global burden of mental disorders.

India was the first country to take the floor affirming that mental health is a subject of the most urgent importance. Many countries recognised the magnitude of the global health problem presented by mental health and described the strategies they are implementing to deal with this issue. A wide range of mental health service policies were evident, ranging from hospital based, to community based, to a lack of formal services.

Denmark, speaking on behalf of the EU, pointed to the social disabilities which disproportionately affect people with mental health problems, including poverty, education drop-out, homelessness and unemployment. Recognizing that mental health has ramifications far beyond the health system, Canada, Costa Rica and other countries affirmed that closer coordination between health and social services is strongly needed. This perspective was reinforced also by Chile, Ecuador and Colombia who argued for the primary health care approach and the development of community-based services.

Many Member States raised the issue of human rights violation and stigmatization of patients with mental health illnesses while others pointed out the importance of providing social services and legislation that guarantee the rights of people suffering from mental disorders.

Zimbabwe and Burkina Faso highlighted the challenges they and other African countries are facing in implementing effective interventions including budgetary constraints and a huge lack of adequately trained human resources. The need to invest in the training of health professionals was backed also by many other countries.

Finally the Secretariat expressed itself pleased to see the level of interest among Member States and NGO and announced that all the comments will be considered in the development of a global mental health action plan that will be presented to the next WHA.

The draft resolution was adopted with some changes proposed by Thailand.

Comment

Pre-debate

Prior to the debate PHM circulated the following commentary on this item.

The Secretariat report provides a very useful overview of some of the problems associated with mental disorders globally. It discusses the epidemiology, social and economic impact and strategies which can be implemented in the health and social sectors.

If the resolution is adopted and implemented it will make a huge difference to the lives of millions of individuals and families. However, there are some missed opportunities here also.

The paper notes the incidence of mental disorders associated with exposure to disasters but is silent on other important determinants of mental health, such as social exclusion, alienation, racism and gender inequities. There is no mention of the linkage between the widening socio-economic inequalities associated with neoliberal economic policies and the current financial crisis and the consequent weakening social solidarity and cohesion, powerful protective and supportive factors.

Poverty and social exclusion, intergenerational unemployment, experience of xenophobia among refugees or the experience of racism in minority settings can powerfully influence how people see themselves in the world and how they respond. These kinds of experiences can contribute to violence, substance abuse and chaotic parenting.

This weakness with respect to the social determinants of health illustrates the fragility of the DG's 'mainstreaming' commitments with respect to SDH, gender equity, trade and health and the right to health.

The discussion of the integration of the medical and social sector and the importance of developing community-based mental health services (Par. 15 and par.22) are useful aspects of this report although there is no reference to primary health care as a strategy for service integration and community based services.

The document is silent with respect to the medicalisation of mental health under the pressure of aggressive marketing of psychotherapeutic drugs by the pharmaceutical industry. The medicalisation of mental illness could have several negative consequences such as a change in the public conceptions of mental illness, an increasing individualisation of social problems and a progressive dislocation of responsibility for social problems. This consequently could create a huge barrier to the development of social approaches to prevention and treatment of mental disorders.

PHM comment following the debate

The focus on 'a comprehensive, coordinated response from health and social sectors' in the report presented to the WHA and in the resolution which was finally adopted is to be commended.

The MS accounts of their own mental health systems during the debate depict a wide variety in standards of care available to people with mental disorders. The resolution which

was adopted commits WHO to support MS in focusing attention on mental health services and the interface between mental health care and social care and protection.

The resolution addresses a huge and complex problem which is everywhere resource starved. For WHO to make a significant contribution will require more resources at HQ, regional offices and in countries. The development of mental health services is part of health system strengthening generally which itself needs to be seen as part of sustainable and inclusive development.

In addressing the interface between mental health services and the social sector the main focus of the report and the resolution is on the social support needs of people with mental, neurological and drug misuse disorders. In this sense the focus was down stream. Neither in the report, nor the resolution nor the debate was there adequate recognition of the social determinants of social, emotional and spiritual well being and the significance of social, emotional and spiritual well being as a dimension of mental health.

The policy pre-occupation with ‘serious mental illness’ and the individualism of private psychiatry and counselling leaves the determination of social, emotional and spiritual well being seriously neglected. Yet the consequences of chronic anger, alienation, anxiety, depression and hopelessness on people’s lives can be profound and self-reproducing. Misuse of alcohol and drugs, interpersonal violence and dysfunctional parenting are powerful mediators through which these emotional disabilities cause further harm and are reproduced. In some degree there are inherited tendencies which may contribute to these disabilities but there are also powerful social determinants including: poverty, prolonged unemployment, racism, exclusion, xenophobia and inequality. The intergenerational harm associated with the interaction of these social pressures and emotional responses is profound. The economic costs in terms of lost productivity are huge.

In this context the apparent downgrading of WHO’s involvement in documenting, analysing and recommending around the social determinants of health is a cause for concern. Chronic anger or xenophobia are not simple problems and there are no magic bullets. They need to be addressed through public policy, supported by community sentiment. ‘Intervention’ here involves giving weight to these issues in a myriad of different public policy decisions in areas such as transport, urban design, labour relations and cultural institutions. The role of public health is to make these issues visible, to describe, to analyse and to demonstrate how public policy can make a difference. The work of the Commission on Social Determinants of Health had a profound impact on the policy conversation regarding these issues with a spreading impact into community consciousness.

The DG has adopted a policy of ‘mainstreaming’ issues such as the SDH and has affirmed strongly that she will take personal responsibility for ensuring that the SDH perspective is manifest across the work of the WHO. However, she has articulated no methodologies for planning, budgeting or accountability to support this commitment.

Advocacy

From a PHM perspective important advocacy themes include:

- promoting the primary health care approach to mental health issues at the community level including care for people with mental health disorders,

- integration of health and social care, promotion of the social determinants of social, emotional and spiritual well being;
- promoting enlightened mental health service policies as part of a wider approach to health systems strengthening;
- engaging with other NGOs and government officials around the social determinants of social, emotional and spiritual well being.

13.3 Nutrition

The issues before the Assembly

Document [A65/11](#) and [A65/11Corr1](#) put before the Assembly a draft implementation plan on maternal, infant and young child nutrition for adoption. The covering note also reports on progress made by countries in the implementation of the International Code of Marketing of Breast-milk Substitutes.

Paper [A65/12](#) provides an overview of the epidemiology, nutrition science and interventions of relevance to nutrition of women in relation to reproduction. The paper lists a number of initiatives which the Secretariat could take up if so commissioned (and funded) to progress the issues canvassed in the paper.

Report of debate

Many positive comments and commendations regarding the comprehensive implementation plan (CIP) were made. Member states also reiterated the importance of and raised concerns about a variety of fronts related to the CIP.

The double burden of under- and over-nutrition and the related NCD burden were mentioned by many countries.

The importance of addressing nutrition through an SDH and PHC lens as well as the need for a multi-sectorial and integrated approach was stressed by Paraguay, Russian Federation, Mozambique, Thailand, India, Iraq, and Morocco.

The importance of focusing on women and children's nutrition and education including support for breast feeding was raised by Denmark, Canada, China, Tanzania, Yemen, and the Marshall Islands.

Regulation in marketing (eg. of breast milk substitutes) and strengthening of related legislation is needed. The marketing and use of ready to use foods is also a concern according to India, Bangladesh, and Thailand.

Opportunities to make a significant impact with some simple initiatives should be taken advantage of including reduction in salt and fat intake that are also very cost-effective, says Denmark on behalf of the EU.

More work is needed on indicators, including possible addition of more indicators such as Vitamin A, access to safe drinking water, micronutrients, wasting, and anaemia according to Jamaica, Bahamas, Japan, Bhutan, and Swaziland.

Surveillance and monitoring are crucial, and a global plan is needed that engages MS and stakeholders at all levels according to Morocco, Denmark, and Canada.

One intervention to improve nutrition, proposed by Paraguay, includes incentives and cash-transfer programs, especially for the very poor, and further attention to poverty as an underlying challenge for nutrition.

Paraguay and the UAE stated that central to an effective strategy for nutrition are the empowerment and education of women—including knowledge of self-defense, birth spacing and family planning.

Finally, Japan and India noted that in addressing nutritional challenges in the world, WHO should provide technical assistance, conduct training relevant to local situation, support integration of effective interventions, and monitor Member States.

Finally the Assembly adopted a resolution on maternal, infant and young child nutrition contained in [the third report of Committee A](#).

PHM comment pre-debate

In the lead up to the Assembly PHM circulated the following comments on this item.

There is a lot which is good in the draft comprehensive implementation plan (CIP) and we welcome many of the components of the plan at the country level. The evidence based approach adopted in the draft is appreciated.

However, the plan is deficient in two main respects: first, it fails to deal with the intersection of trade relations and nutrition; and second, it steers clear of the challenges to be faced in building a regulatory framework to regulate transnational agribusiness and food corporations at global and country level.

In contrast to the failure to confront the regulatory challenge, new provisions regarding investor state dispute settlement, now being inserted into preferential trade agreements, provide transnational corporations with powerful new defenses against regulation at both the national and international levels. This has been clearly demonstrated in the attack by Big Tobacco on the plain packaging policies of Uruguay and Australia. Resolution [WHA59.26](#) (p37) mandates the WHO to work with MS to achieve coherence across trade and health policies. This must be maintained.

The commercial interests of transnational agribusiness, food corporations and retailers play a powerful role in shaping nutrition and malnutrition through marketing and through price relativities. The challenge of regulation must be faced. Diets of the poor everywhere are deteriorating, particularly in middle income countries with significant urban populations.

Trade and commercial factors contribute powerfully to obesity in children and its relation to NCDs. Nutrition cannot be addressed in isolation from NCDs. We urge MS to take advantage of the momentum created by the UN High Level Meeting on NCDs.

Nutrition needs to be understood in the context of food security (and insecurity). Speculation in food commodities due to deregulation of commodities derivative markets in 2000 was the main factor in a 50% rise in food prices in 2008. More than 200 million

hectares of land have been sold, mainly to transnational companies, and mainly in Africa, over the past decade. The employment generated seems to be greatly outweighed by displacement of small producers. Meanwhile the diversion of land and grain from food to biofuels is contributing to rising food prices and jeopardising food security and nutrition.

The stalemate in the so-called Doha Development Round in the WTO leaves in place agricultural subsidy and protection policies which have been highly detrimental to small producers.

There has been a somewhat uncritical acceptance of ready-to-use therapeutic foods (RUTF) in settings which go beyond the treatment of severe acute malnutrition. Its widespread and unregulated use poses a threat to breast feeding and by promoting the magic bullet approach diverts attention from the structural reforms needed to address food security.

WHO cannot address the issues of trade and the regulation of transnational industry alone but it can take a pro-active stance in working with other competent intergovernmental bodies.

[A65/12](#) is a useful paper. It is good to see attention given to the non-clinical aspects of prevention and ‘treatment’ including water and sanitation. Clearly a multi-sectoral approach is called for with a focus on food security.

Effective planning for food security and food-related prevention and response to disasters is very important for meeting the nutritional needs of mothers and young children; such a strategy also requires the cooperation and integration of multiple stakeholders and sectors.

Read [PHM's statement to the Committee on this item](#)

PHM comment post debate

The issues touched upon in this debate are hugely important in shaping the health and life chances of billions of people. It is good that WHO is taking a leadership role with respect to many of the key issues. The evidence based approach adopted in these reports is an important contribution.

However, WHO’s reluctance (or inability) to confront the trade dimension of malnutrition and the need to regulate the transnational supply chain, is a serious weakness. WHO cannot address food security and adequate nutrition by itself but it has an obligation to identify all of the causes of malnutrition including the structural determinants such as trade, agriculture policy and food marketing. Clearly while the donor countries control WHO’s agenda its capacity to speak truth to power is muted.

The Secretariat’s report on compliance with the Code for the Marketing of Breast Milk Substitutes demonstrates poor compliance in many countries. Exclusive breast feeding rates to 6 months is estimated at 37% globally. The Code should have been cast as a binding statute from the beginning and it is time to create such an instrument.

Food (in)security is a very direct reflection of unequal access to resources and the unequal power relations which perpetuate unequal access to resources. Over-nutrition in the rich countries, including excessive meat intake, contributes directly to the undernutrition of

poor people in poor countries (not to speak of biofuels). In this context the pre-occupation of certain MS with micronutrients and ready to use foods in the face of widespread protein calorie malnutrition is not appropriate. The unequal power relations which maintain an unfair distribution of foods are reflected in the current governance structures of WHO.

Advocacy themes

From a PHM perspectives some of the important themes and strategies for advocacy include:

- building closer links between PHM and activist organisations working on various other aspects of the problem including small farmers' rights, food security, labour rights, trade and health as well as nutrition;
- reviewing and documenting the nutrition priorities at country level and developing policies and strategies to address these;
- ensuring that debate over nutrition policy incorporates consideration of the social determinants of health, health system strengthening and in particular the building of primary health care.

13.5 Monitoring the achievement of the health related MDGs

Issues before the Assembly

Document [A65/14](#) provides the annual report on the progress in achieving the MDGs and shows that substantial progress has been made even though large gaps persist between and within countries. the Assembly was invited to consider global health goals after 2015.

Document [A65/15](#) reports on the finalisation of the Commission on Information and Accountability for Women's and Children's Health (focusing on MDGs 4 & 5) and the implementation of the recommended monitoring mechanisms for which WHO has responsibility.

Debate

The discussion focused on two reports from the WHO Secretariat: one progress report on the health related MDGs which included also a section on global health goals after 2015 and a document on the implementation of the recommendations of the Commission on Information and Accountability for Women's and Children's Health. Resolution EB130.R3 was also considered.

All countries emphasized the importance of this agenda item and recognized that even if substantial progress has been made, large gaps still persist between and within countries. Many countries were particularly concerned about the lack of progress in reducing maternal and infant mortality.

Iran pointed out that the main obstacles in achieving the MDGs are an insufficient political commitment and huge inequities in the allocation of health resources.

Mauritius, on behalf of AFRO, stressed the importance of health systems strengthening, access to effective medicines and alignment of external resources with national priorities.

The importance of health system strengthening was also reiterated by Switzerland and Canada.

The need for increased efforts to address the social determinants of health was stressed by several countries.

Mexico and Ethiopia recalled the importance of monitoring and ensuring quality of data by strengthening health information systems.

Concerning the goals after 2015, many countries appreciated the Secretariat's strategic thinking about global health goals after 2015. Norway recalled the new challenges the world will face in the following years (such as climate change, NCDs, food security, geopolitical changes). These challenges should be taken into account in setting the new goals. Other countries stated that the new framework should focus on sustainable development. Brazil and Japan affirmed that, even if they support the discussion on the goals after 2015, they think that WHO and Member States should firstly concentrate on the achievement of the past MDGs and asked WHO to continue its efforts in this area.

The Assembly adopted the resolution proposed by the EB on the monitoring of the MDG health related goals. See [Third draft report of Committee A](#)

PHM comment

In the lead up to the Assembly PHM circulated the following note regarding this Item.

Some people working in public health are worrying that 'health will lose out' in a new post 2015 set of global goals, mooted to be adopted at Rio+20 in June 2012.

It is anticipated that a new set of goals based on the idea of inclusive and sustainable development will be adopted. This could be a significant improvement on the MDGs. While the huge increases in foreign assistance for health since 2000 have saved lives they have not directly addressed social, economic and institutional development.

With a new focus on inclusive and sustainable development there will be opportunities to progress the issues of health system strengthening and action on the social determinants of health.

The recommendations of the Commission on Information and Accountability and the accountability mechanism being put in place provide an interesting case study in the mutual accountability of nation states.

Themes for advocacy

From a PHM perspective the main theme for advocacy are:

- support for a new set of global goals which focus on inclusive sustainable development; these can and should include health systems strengthening and action around the social determinants of health as core elements of inclusive sustainable development.

13.6 SDH: outcomes of the World Conference

The issues before the Assembly

The [Commission on the Social Determinants of Health](#) was established by the Director-General of WHO in 2005 as a ‘global network of policy makers, researchers and civil society organizations’ ([see more](#)) to address social causes of illness and issues of inequity. It issued its final report in 2008 ([Closing the Gap in a Generation](#)). Resolution ([WHA62.14](#)) on SDH requested the DG to convene a global event before WHA65 in order to discuss renewed plans for redressing the alarming trends of health inequities through actions on the SDH.

Document [A65/16](#) is the report by the Secretariat on the process and outcome of the World Conference on Social Determinants of Health (Rio de Janeiro, Brazil, 19–21 October 2011), and also summarizes progress on the implementation of resolution WHA62.14.

The WHA65 is invited to adopt the resolution ([EB130.R11](#)) (Outcome of the World Conference on SDH), which includes identified actions for member states (and particular actions for the donor countries), for the ‘international community’ and for the Secretariat.

Report of discussion at WHA65

Several member states reported on progress with respect to SDH in their countries including Trinidad and Tobago, Iran, Algeria, Japan, and Chile.

Nearly every country expressed appreciation to WHO and Brazil for organizing and hosting the World Conference on the Social Determinants of Health in Rio de Janeiro in October, 2011, and emphasized the importance of keeping SDH high on the agenda. There was no further discussion of the inclusion of SDH as an ‘overarching priority’ in the Global Program of Work rather than as a ‘category’ since this had been discussed at length in an earlier session on WHO reform.

Many countries urged the WHO, and each other, to retain their commitment to work on SDH and to translate that commitment into action. They also urged WHO to take a leading role in moving this agenda forward and supporting Member States as they faced challenges within their specific country contexts. It was acknowledged that effective progress on the SDH would require partnerships within and among sectors and collective action.

Furthermore, member states called for WHO to ensure that health remains prominent in the upcoming Rio+20 Conference and to consider the five key areas in the 2011 Rio declaration in the ongoing WHO reform process. Denmark emphasized the need to ensure that health inequities are taken into account in the Helsinki Conference on Health Promotion and several countries including Brazil, Denmark, and Thailand all highlighted the importance of developing the ‘health in all policies’ approach which will be the focus of that meeting. Member States including Denmark, Iran, and India emphasized health systems (variously health systems strengthening, universal health coverage, and primary health care) as critical infrastructure for driving the SDH approach to address health inequality. Member states addressed the need to promote international cooperation and solidarity to address wide gaps between and within countries. Norway also emphasized the need for resources to be allocated towards these ends.

Civil society urged WHO to recognize migration as a determinant of health during the Helsinki conference. They also impressed upon WHO the need to improve the participation of civil society (including young people) in policy making. Finally, they emphasized the need to ensure that any indicators adopted for monitoring SDH in various programs are disaggregated using meaningful stratifiers.

The resolution passed without any amendments.

PHM pre debate comment

Prior to the Assembly PHM circulated the following comment on this agenda item.

Action on the SDH is a critical component of Primary Health Care (Declaration of Alma-Ata 1978) and a prerequisite of eliminating health inequities. The PHM welcomes the progress in the analyses mandated by Resolution [WHA 62.14](#) (see p 21). However in the absence of any provision in the new GPW framework for the management and accountability for cross cutting issues such as SDH carries a serious risk that this work will be allowed to wither.

A commitment to addressing the SDH needs to be incorporated into all aspects of policy making. Political will is an essential element for work on SDH including the political will of higher income countries to support moves to a more equitable and sustainable allocation of global resources. Many higher income countries have benefited unjustly from their relationships with lower income countries and should work to rebalance the maldistribution of power and resources.

“The social determination of health is much more than a collection of fragmented and isolated “determinants” that, from a reductionist viewpoint, are associated with classic risk factors and individual lifestyles. We must not allow the concept of social determinants of health to become banal, co-opted or reduced merely to smoking, sedentary behaviour and poor nutrition, when what we need is to recognize that behind those symptoms and effects lies a social construction based on the logic of a globalized hegemonic culture whose ultimate goal is the commercialization of life itself.” ([Civil Society Position, Rio](#)) The social determination of health need to be properly embedded in policy-making around non-communicable diseases, too, so as to not stigmatise individuals while letting corporate agents off the hook or dismissing the socio-economic causes of the causes.

WHO is properly concerned with measurement and evaluation. However, unless the indicators adopted for monitoring various programs are disaggregated using meaningful stratifiers, progress on the SDH remains invisible. We call for continued research, monitoring and evaluation, health impact assessments, and support to address the root causes of the inequities underlying the SDH.

WHO has a leading responsibility to demonstrate leadership on SDH within the UN system. There is a need to further develop the capacity of the Secretariat to provide technical assistance in the implementation of the Rio Declaration. We also urge Member States to approve the necessary funding for the work on SDH as detailed in the respective [Report on financial and administrative implications](#).

WHO has a key role in ensuring that initiatives to address the SDH are included in other UN deliberations and programs, e.g. Rio+20 and the post-2015 development

framework. The Health in All Policies approach demands that SDH are addressed in areas such as trade, taxation, TNCs, financial institutions, and privatization of social programs.

A major consideration is how to manage the conflicts of interest within global health decision-making institutions and we call for a code of conduct to help facilitate this process.

[Statement read to Committee A](#)

PHM comment post debate

The SDH department within WHO has been seriously underfunded since the closure of the CSDH. Presumably this reflects donor choice. Hopefully the positive comments of Norway, Belgium and Brazil may presage some additional funding when the financing dialogue takes place.

SDH is properly regarded as a cross-cutting issue with implications for communicable disease, non-communicable disease, health systems and emergencies. However, it is also an area of technical expertise with responsibilities for supporting both regions and countries and identified projects (such as HIAP) through which to drive the SDH approach.

The DG has indicated that SDH and other cross-cutting issues will be located in her office and she will take personal responsibility for ensuring it is mainstreamed. However, there has been no elaboration of a methodology to support planning, budgeting, accountability and advocacy in relation to both the cross cutting dimensions and the technical support/ project work.

Advocacy themes

From a PHM perspective some of the main advocacy themes will be:

- advocating at the country level for implementation of the resolution on social determinants arising out of the Rio Conference;
- continuing to promote action on the SDH through engaging with relevant policy issues and advocating for a systematic approach to ‘health in all policies’.

13.7 Implementation of the International Health Regulations

Issues before the Assembly

The Assembly was invited to note the annual report by the Director-General on the implementation of the IHRs ([A65/17](#)). This annual report on IHR implementation was mandated by resolution ([WHA61.2](#)) requiring that States Parties and the Director-General would report annually to the Health Assembly on the progress made in implementing the Regulations.

The debate

The report on the implementation of the International Health Regulations (2005) was discussed by Committee A. Many member states note the slow progress being made in some countries.

Key challenges cited as reasons for the slow progress are:

- capacity weaknesses in relation to IHR (in areas such as border health controls, surveillance, chemical and radio-nuclear material threat);
- weak laboratory capacities;
- difficulties with regard to financial resource mobilization;
- balancing the focus on communicable diseases with challenges in food safety and nutrition.

In the light of these challenges, Member States recommend that the WHO continue efforts at mobilizing resources to support implementation and to advocate for actions beyond the health sector. A number of countries, including Brazil, Russia, and Germany, expressed their willingness to share technical expertise with other countries.

Some Member states requested for extension of the 15th June 2012 deadline to allow more time for implementation. The report was noted, and the resolution approved with 14 amendments.

PHM Comment

The IHRs are the direct descendants of the Sanitary Regulations of the 19th Century. After the SARS crisis of 2003 the MS accelerated the processes of review of the IHRs and a reconceptualised and stronger version was finalised in 2005. The Fukushima Daiichi nuclear crisis in Japan is cited in this report as an example of the need for a functional prevention and response strategy.

Critical to the success of the IHRs is country level capacity and the capacity of regional and global institutions. The report notes priorities and progress made to this point in setting up monitoring systems, strengthening laboratory capacity, and tools for inspection and planning in countries.

The report notes that a significant number of countries will not meet their goals for establishing core capacities by the deadline of June 15, 2012.

It may be that in some ministries of health there is a sense that capacity building for the IHRs is not a top priority. Such a view could have been reinforced by the virus sharing controversy during the H1N1 pandemic. However, emergency preparedness should be a priority. Pandemics can wreak havoc in any country, rich and poor. Public health capabilities are needed for preparedness and response for national outbreaks as well as outbreaks which threaten to cross borders.

PHM urges WHO to consider closer collaboration with civil society and with public health professional organisations to strengthen the accountability of MS regarding capacity building for public health emergency preparedness.

13.9 Pandemic Influenza Preparedness: sharing of influenza viruses and access to vaccines and other benefits: report on the work of the Advisory Group

The debate

Under this agenda item, Member States discussed the implementation of the [Pandemic Influenza Preparedness \(PIP\) framework](#) on access and benefit sharing of influenza viruses, agreed last year as the Standard Material Transfer Agreement (SMTA).

There was general satisfaction among MS of the work of the Advisory Group, and calls for speeding up the process of putting the SMTAs into action.

Several MS called for strengthening surveillance capacity at national level as part of the preparedness plan investment they wish to benefit from.

Nepal, speaking on behalf of South-East Asian Region (SEARO), was confident that the implementation of the framework will promote equity. Nepal commented on the fact that one year has passed since the adoption of the framework without being actually implemented.

Nepal requested the DG to report to the 66th WHA and subsequent two WHAs via the EB on progress at this front.

Thailand, which aligned itself with the statement of Nepal, requested the DG to accelerate this work. Thailand noted that there is currently no global or MS mechanism to regulate research in this field, and urged the WHO to work with MS and other key parties to move forward on a mechanism to safeguard public health against potential negative consequences.

Denmark, speaking on behalf of the EU, welcomed the recommendations made by the Advisory Group, in terms of working more towards preparedness than response, hence supporting the proposal to use 70% for preparedness and 30% for response

China mentioned that its experts participated in drafting the report concerned. With the support of the WHO, China has made remarkable progress in surveillance and preparedness, it noted, and will continue to participate and support global surveillance and make donations to international vaccine reserves.

Brazil highlighted the role of the PIP advisory group as a central in the implementation of the framework. Brazil appreciated the way the advisory group is conducting dialogue with industries, and noted that sharing of knowledge and technologies with developing countries is crucial.

In Brazil's view, partnership contribution is crucial, and this could be a good example also for our discussion on the reform process.

Ivory Coast highlighted the importance of access to vaccines particularly during pandemics, and encouraged equitable distribution of benefits. It called for WHO support in strengthening surveillance.

The USA said they remained strongly committed to the PIP framework and looked forward to its implementation. The USA reminded MS of the financial responsibility

contained in the PIP framework, noting they were themselves financial contributors to the process. The delegation was pleased that during advisory meetings WHO has found ways of including other stakeholders, noting the importance of the involvement of industry and civil society. The USA was also pleased to be a financial contributor to this process.

In a joint statement, some public interest civil society organisations (Health Action International, Third World Network, Berne Declaration and PHM) expressed their disappointment regarding the fact that over the past one year, no SMTAs have been exchanged, although biological materials have been shared. They demanded to have timelines within which WHO will implement.

They also said that the Secretariat should provide details of what will be included in pandemic preparedness, and stressed that for equity, there's need for transparency, requesting for the publication of the annual report.

The WHO's Secretariat's response was by Dr. Keiji Fukuda who noted that the PIP framework is the first of its kind, and would help to democratise the process among MS. He said the process is moving forward with all possible speed; however it is challenging. He mentioned the publication of the handbook on PIP framework which is available in all official languages as well as a website.

In response to questions about SMTA2, Dr. Fukuda said that discussions have been raised between the DG and CEOs of several corporations, and these companies recognised the importance of the framework and its implementation. These discussions will expand to involve more companies, including in developing countries.

In her concluding remarks, the DG said that the WHO is in a difficult situation in terms of proceeding with partnership regarding financing. The DG wanted to be "careful" in the way the WHO discusses financing with industry in order to avoid conflict of interest, particularly after calls from the civil society to speed up the process.

The Assembly noted the report of the Advisory group.

During the 131st session of the EB, following the WHA, there was a brief discussion of PIP, in which EB Members reiterated the views expressed during the Assembly. Morocco said they hoped to expedite conclusions on SMTA2, and called for a focus on equity considering the vulnerability of some countries. Likewise, China called for strengthening surveillance and country capacities, while giving the DG flexibilities in the management of outbreaks.

On a different note, the USA asked about the specific uses of the framework funds and how stakeholders will be consulted during the process.

See [Statement read on behalf of HAI, Berne and TWN](#)

13.10 Polio: intensification of the global eradication initiative

The issues before the Assembly

Two papers were before the Assembly: first, a report by the Secretariat on the current state of progress towards polio eradication ([A65/20](#)); and second a resolution forwarded from

the EB urging a redoubled effort from MSs and the Secretariat to complete the ‘end game’ of polio eradication ([EB130.R10](#)).

Report of debate at WHA65

All Member States appreciated the intensification of the global polio eradication initiative and the [Global Polio Emergency Action Plan 2012–2013](#) to support Afghanistan, Nigeria and Pakistan, agreeing “that the risk of failure to finish global polio eradication constitutes a programmatic emergency of global proportions for public health and is not acceptable under any circumstances”.

The report states also that the Strategic Advisory Group of Experts (SAGE) on immunization will provide recommendations on the actual implementation.

The main open issues are:

- how the removal of Sabin polioviruses from immunization programmes should be phased, beginning with the particularly problematic Sabin type 2 poliovirus;
- the availability of bivalent oral poliovirus vaccine, and new low-cost approaches for the use of inactivated poliovirus vaccine;
- the risk of international spread which will continue until the complete eradication of polio; and
- implementation of all basic routine vaccinations.

During the discussion Kenya expressed concern about not being ready to move from OPV to injectable vaccine because of the active circulation of the virus in the country and lack of sanitation plus the higher cost of IPV.

Nigeria asked for an implementation of the epidemiological surveillance introducing GPS mapping and HIS system to focus on high-risk areas and reaffirmed the importance of building relationships with community and religious leaders.

After the discussion the draft resolution was finally approved. The Secretariat affirmed that WHO is working in close collaboration with GAVI and UNICEF to mobilize resources, especially for the extra cost of IPV and the DG encouraged all Member States to redouble the efforts to succeed in the eradication.

PHM Comment

The Secretariat report is a useful review of the state of play. Perhaps in its next iteration there might be some reference to the reasons for the 2011 polio recrudescence and to the case management of people affected by polio.

The resolution ([EB130.R10](#)) declares the completion of poliovirus eradication a programmatic emergency for global public health and provides a strategic path forward; hopefully it will attract government and donor [support](#).

Complete eradication of polio virus necessitates continuous monitoring of occurrence of new infections. Health systems strengthening and development of the necessary human capacities need to be in place for proper surveillance.

The eradication of polio should not be reduced to vaccination. Polio should be seen within the context of SDH. Other strategies (including access to safe water and sanitation) have a key role to play in the process of polio eradication.

The Global Polio Eradication Initiative has faced difficult challenges recently, with Afghanistan, Nigeria and Pakistan experiencing a significant increase in new cases in 2011 compared with 2010. For these reasons the Global Polio Eradication Initiative intensified its extensive programme of work.

The Independent Monitoring Board has declared that the emergency approach must be extended to front-line workers, especially in Pakistan and Nigeria which “represent the gravest risk to global eradication”.

This approach involves considering additional measures such as the possibility of using the International Health Regulations to limit the potential spread from affected countries (para 6). For some emergency eradication activities more financing will be required.

In the new Global Polio Emergency Action Plan 2012–2013 a more efficient medium-term strategy is being examined, combining the eradication of residual wild poliovirus transmission with the polio “endgame” strategy designed to deal with vaccine-derived polioviruses.

13.11 Elimination of Schistosomiasis

Issues before the assembly

The Assembly had before it a report from the Secretariat on the elimination of Schistosomiasis ([A65/21](#)) and a draft resolution forwarded from the Executive Board ([EB130.R9](#)).

The report mentions that the goal of resolution [WHA54.19](#) on schistosomiasis and soil-transmitted helminth infections (regular administration of chemotherapy to at least 75% and up to 100% of all school-age children at risk of morbidity in endemic areas by 2010) has not been achieved.

The report notes progress in expanding schistosomiasis control, particularly through large-scale schistosomiasis treatment carried out in endemic countries.

The draft resolution urges redoubled efforts and funding including attention to sanitation and water supply as well as mass medication.

Debate

It is worth noting here that the DG mentioned schistosomiasis in her opening address to the 65th WHA on its very first day. Dr Chan referred to schistosomiasis in the context of neglected tropical diseases, and thanked the commitment by the pharmaceutical industry in January, which enabled the WHO to give drugs to schistosomiasis to everyone who needs it.

Under this agenda item, the Secretariat introduced the issue of schistosomiasis as a global health problem which affects 200 million people worldwide.

A draft resolution on the elimination of schistosomiasis was considered by MS (EB130.A9, adopted as [WHA65.21](#)).

Morocco spoke on behalf of EMR countries and shared about initiatives which had been launched for the elimination of schistosomiasis, noting that the proposed resolution text fully met their expectations. Morocco proposed amendments to the text, including reference to a mechanism for the interruption of transmission, and to providing support to countries certified as not having schistosomiasis to prevent its reintroduction in these countries.

The USA said they continued to support this issue, given its economic impact in developing countries, and applauded the extension of control programmes. The USA noted the advances to make available praziquantel, and the efforts by private pharmaceutical companies in this regard, and highlighted the importance of post-treatment surveillance.

The International Federation of Pharmaceutical Manufacturers Associations (IFPMA) delivered an intervention on the increasing praziquantel donations by pharmaceutical companies, highlighting the number of tablets donated.

The draft resolution was adopted with the proposed amendments.

PHM Comment

PHM wishes to caution against the emphasis of medical and vertical models of addressing schistosomiasis, which should be placed in the particular socio-environmental context of the country where it is prevalent. Making treatment available, by increasing the size of donations of praziquantel, is not the one and only solution to this problem. Social determinants of health should be considered as well in order to put schistosomiasis in the correct context.

At present only 12% of people at risk of schistosomiasis morbidity and 23% of school-age children at risk of morbidity due to soil-transmitted helminthiases have benefitted from preventive chemotherapy with praziquantel and with benzimidazoles, respectively.

It is misleading to say that “global supplies of praziquantel are insufficient”, and that “lack of praziquantel is the major barrier to schistosomiasis control”. Praziquantel is a cheap medicine and it is readily available in developing countries with basic pharmaceutical production capacity.

Schistosomiasis has deep cultural and socio-economic root causes which go beyond the unavailability of praziquantel. It is primarily a disease of social determinants including poor hygiene and lack of access to clean water and sanitation. This is mentioned in the [WHO fact sheet on schistosomiasis](#): “people are at risk of infection due to agricultural, domestic and recreational activities which expose them to infested water”, and that “hygiene and play habits make children especially vulnerable to infection”. Schistosomiasis has its deep roots in geography and the culture of those societies where it is endemic; its eradication will require holistic approaches.

The proposed resolution ([EB130.R9](#)) does not set out a comprehensive short, medium and long-term plan for the elimination of schistosomiasis. Strategies should include but go beyond resource mobilisation for mass preventive treatment. While mass praziquantel treatment is effective in controlling the burden of morbidity from schistosomiasis, elimination

of the disease calls for a more broad-based strategy. Strong intersectoral collaboration is needed to ensure that such projects are planned with full consideration of the implications for all soil transmitted infections.

13.12 Draft global vaccine action plan

Issues before the Assembly

The Assembly is invited to consider Document [A65/22](#) (an updated draft of the global vaccine action plan) and a draft resolution is foreshadowed but not listed among the documents circulated for the Assembly.

A resolution on World Immunisation Week is forwarded from the Executive Board ([EB130.R12](#)) for consideration by the Assembly.

Report on Discussion at WHA65

All Member States welcomed the draft strategy recognizing that, as part of a comprehensive package of interventions for disease prevention and control, vaccines and immunization are essential; the guiding principles and implementation strategies of the draft are clear and precise and objectives and accountability framework are acceptable.

Several MS warned that the availability of funding for immunization programmes is threatened by the financial crisis, this is a big issue especially for countries which are not GAVI-eligible.

India warned that the introduction of new vaccines should not to be pushed by vested interest groups. Introduction of new vaccines should be determined by country authorities on the basis of burden of disease, manufacturing capacity within country and affordability. Improved coordination and funding of R&D is needed to create new vaccines at affordable prices.

Several MS spoke about the need to address public resistance to vaccination programmes.

Several MS spoke about the importance of strengthening health systems to support the delivery of routine and campaign-oriented vaccination and improvements in the coverage and integration with other public health interventions.

Thailand also has doubts on the world immunization week, because of the risk of vaccine manufacturers using it as an occasion for building pressure on country authorities to add new vaccines to the schedule. MS focus should be on the basic vaccines.

MSF asked for better data, for more targeted interventions and for more thermostable products for better delivery.

The resolutions on the Global Vaccine Action Plan and on World Immunization Week were both adopted with some minor amendments.

After the discussion the Secretariat assured MS that WHO will lead the efforts for norms and standards and will provide support at country level for the implementation of existing partnerships and coordination structures without creating new structures. It was

decided to refine the framework with better indicators and targets with the aim of submitting the draft framework to SAGE (Strategic Group of Experts) and to report to the next WHA through EB.

PHM Comment Pre-debate

Clearly the wider application of vaccination to more diseases and to more people promises huge improvements in global disease burden (although there are risks that the magic bullet paradigm obscures the need for attention to the social determinants of health and social justice / distributional considerations).

There is wide scope for improvements in the current range of vaccines including more multivalent vaccines and heat stable products. Likewise there is a pressing need to support local vaccine production and more broadly based development capacity.

New vaccines are generally quite expensive and the decision to put them on the national immunisation schedule will always have opportunity costs as well as gains. It is essential that appropriate cost effectiveness studies are undertaken before committing to new vaccines. Such studies need to take into consideration disease burden, immunisation delivery capacity, wider health service priorities and resources.

Vaccine manufacturers need to adopt responsible marketing strategies or have appropriate codes or regulations put in place.

Advocacy themes

- HSS is key to routine effective vaccine delivery.
- L&MICs need to retain sovereign control over their immunisation schedules and not have them imposed through global standards or marketing strategies.

13.13 SSFFCMP (substandard, spurious, falsely labelled, falsified, counterfeit medical products): report of a working group of member states

The issues before the Assembly

From the 1980s Big Pharma has been concerned regarding calls for WHO to provide more support for the rational use of medicines. From the early 1990s Big Pharma has been looking for ways to harness the authority of the WHO in the defense of intellectual property ‘rights’ (as defined within increasingly restrictive IP regimes). From the late 1990s Big Pharma has been increasingly apprehensive about the delegitimation of the patent regime upon which it depends for its profits.

The International Medical Product Anti-Counterfeit Taskforce (IMPACT) was a strategy adopted by Big Pharma as a collaboration between the International Federation of Pharmaceutical Manufacturers (IFPMA) and WHO. This was a ‘partnership’ which was never authorised by the Assembly. IMPACT was designed to take advantage of ambiguities around the meaning of ‘counterfeit’ and which deliberately conflated the policing of QSE

compromised medicines (compromised with respect to quality, safety and efficacy) with the policing of (claimed) intellectual property rights.

From the mid 2000s WHO has been subject to increasing criticism from civil society for its association with IMPACT (including organisational and internet hosting) because of the use of WHO resources and authority to police often contentious IP claims, a function which lies far beyond WHO's constitutional mandate.

There have been strong calls to dissociate WHO from IMPACT and to clearly demarcate WHO's public health mandate, concerning quality, safety and efficacy (QSE) compromised medicines, from the policing of various IP regimes.

An Open Ended Working Group of Member States was established by WHA63 and met in February and October 2011 with the aim of finding ways of ensuring the QSE and affordability of medicines. The Working Group prepared a report ([Document A65/23](#)) which includes the proposed member state mechanism.

The report reaffirmed WHO's role in ensuring the availability and affordability of quality, safe and efficacious medical products and highlighted the lack of finances for work needed in this important area.

The report outlines the goal, objectives, structure, meetings, relations with other stakeholders and experts, reporting and review and transparency and conflict of interest provisions associated with the proposed MS Mechanism on SSFFC medical products.

Report on debate

The 65th WHA approved the new Member State Mechanism (as recommended by the Working Group) to address substandard/spurious/false-labelled/falsified/counterfeit (SSFFC) medical products.

There was a generally positive feeling among delegations as they welcomed the establishment of the mechanism, which aims at looking into the problem of SSFFC medicines from a public health perspective excluding intellectual property considerations.

The EU asked the WHO to secure the necessary financial means for the MS mechanism in the next programme of work.

At the same time, there were also calls for transparency and comprehensiveness in the implementation of the mechanism.

Members emphasised the important role the WHO has to play in ensuring quality, safety and efficacy (QSE) of medical products, given the organisation's mandate. Members further requested that drug regulatory capacity, including market surveillance and pharmacovigilance, be developed in countries where it is inadequate or non-existent. Brazil highlighted the need to address the root causes of QSE compromised medicines to efficiently prevent SSFFC from further penetrating markets. They called for making medicines accessible for the poor.

Some countries also raised the problem of medicines sold over the internet.

Some interventions stood on a different ground. For example, Nigeria called for an international convention on counterfeiting, saying that medical counterfeiting requires

international efforts. Bahamas, surprisingly, attributed the prevalence of SSFFC medical products to parallel importation, one of the flexibilities in the TRIPS Agreement which provides means for accessing medicines.

Indonesia pinpointed an important point by raising the question of how the mechanism will be translated into an action plan. The 65th WHA did not answer this question last week. There is no clarity on this matter at this point in time.

The first conference on SSFFC medical products will be held in Buenos Aires, Argentina in October. The Union of South American Nations (UNASUR) expressed their wish to hold the first meeting of the MS mechanism during this conference; however, there were reservations from several countries such as the EU and Mexico.

See [statement by WCC, TWN and PHM to the 65th WHA on SSFFC](#)

PHM Comment

WHO should withdraw its support for IMPACT. The IPRs that IMPACT seeks to police are often contentious and the role of high levels of IP protection in denying many people access to medications is also contentious.

The problem of QSE compromised medicines is very real and must be addressed. WHO has a critical mandate with respect to the regulation of medicines to ensure quality, safety, efficacy, rational use and affordability. The effective regulation of QSE depends on adequately resourced and well functioning drug regulatory agencies at the country level, WHO has a critical mandate to support the development of drug regulatory capacity at the country level and to support regional collaboration in drug regulation.

The market for QSE compromised medicines is reinforced by the high prices of quality medicines. The high prevalence of compromised medicines reflects in some degree the failure of some member states to invest in drug regulation, and the failure of donors to support such regulation. It also reflects the lack of capacity within the WHO Secretariat to provide proper support to capacity building for drug regulation both at the country level and through regional collaboration.

The lack of capacity within WHO to properly support capacity building in this critically important area reflects the deliberate choice of member states to restrict the untied assessed contributions to WHO and to make it dependent on tied donor funds. Clearly the donors have chosen to choke WHO's role in drug regulation while supporting IP policing through IMPACT.

This reflects a massive conflict of interest. The large member states who provide the bulk of the earmarked funding to WHO are also home to large originator pharmaceutical manufacturers which represent significant fractions of national export earnings and tax revenues. IP policing (in association with increasing levels of IP protection) is a necessary part of maintaining export earnings. Big Pharma would have no objection to WHO promoting capacity building with respect to QSE compromised medicines but they are determined to prevent action on the rational use of drugs, essential drug lists and single payer reimbursement schemes based on cost effectiveness.

The WG on SSFFC clearly reached a stalemate. The proposed ‘member state mechanism’ will keep the dialogue alive and will keep the focus on WHO’s role in capacity building for drug regulation. This is good. However, under this compromise WHO will continue as a member of IMPACT and will continue to bestow its legitimacy on the use of the ‘health objective’ as a cover for policing IPRs.

PHM calls on MS to dissociate WHO from IMPACT; to properly fund the drug regulatory capacity building role of WHO at global, regional and country levels; and to resolve the financial crisis of WHO by increasing assessed contributions and converting tied donor funding to untied donations.

Themes for advocacy

From a PHM perspective some of the key advocacy themes include:

- following the new MS ‘mechanism’ and ensuring that it does lead to appropriate policies and systems to support affordable, quality, safe and efficacious medicines as well as the rational use of medicines;
- meanwhile all efforts to strengthen drug regulatory agencies at the national level should be supported as well as country level efforts to promote the rational use of medicines;
- continuing emphasis on the need to separate the issues of QSE compromised medicines from the policing of claimed IP rights;
- continued emphasis on the full use of TRIPS flexibilities;
- opposition to continued patent term extensions and limits on national medicines reimbursement schemes through bilateral and regional free trade agreements.

13.14 CEWG (consultative expert working group) on research and development: financing and coordination

The issues before the Assembly

Before the Assembly was the report of the [Consultative Expert Working Group \(CEWG\)](#) established as part of the implementation of the [Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property \(GSPA\)](#). The CEWG brief was to recommend alternative ways of funding R&D for medical products for diseases and conditions disproportionately affecting developing and least developed countries. These conditions do not represent lucrative markets for Big Pharma and as a consequence do not attract appropriate levels of investment. Accordingly the policy goal is to delink the cost of R&D from the final over the counter cost of the product, which is borne by the patient.

In the 130th EB session in January, a shorter version of the CEWG report was discussed although the full report came out later in April. The CEWG recommended working towards a binding agreement on financing and coordination of R&D. There was some reluctance among some Member States regarding the binding character of the proposed instrument on health R&D and reluctance to see it discussed at this Assembly.

The CEWG report lists the elements of the proposed binding agreement, providing a framework for negotiations. The proposed elements include, among others: promoting R&D for developing new health technologies for addressing the global challenges constituted by the health needs of developing countries by securing access and affordability through de-linking R&D costs and the prices of the products; securing sustainable funding to address identified R&D priorities in developing countries; improving the coordination of public and private R&D; enhancing the innovative capacity in developing countries and technology transfer to these countries; improving priority-setting based on the public health needs of developing countries.

In its report, the CEWG proposes: (i) the establishment of a working group or technical committee to undertake the preparatory work on the elements of a draft agreement; and (ii) the establishment of an open-ended inter-governmental working group with appropriate technical support (as in the case of the WHO Framework Convention on Tobacco Control). The CEWG also recommends the allocation of sufficient resources to support the working group.

The time has come for Member States to begin a process leading to the negotiation of a binding agreement on R&D relevant to the health needs of developing countries under Article 19 of the WHO Constitution. This would put on a secure footing the implementation of the GSPA-PHI which Member States agreed in 2008, and in particular the sustainable financing of R&D

Report of debate at WHA65

Member states at the 65th World Health Assembly (WHA) adopted a resolution calling for increasing investments in health research and development (R&D) which corresponds to the needs of developing countries.

The resolution, however, did not commit to the binding convention as recommended by the report of the Consultative Expert Working Group (CEWG) on R&D financing and coordination and as proposed in draft resolutions submitted by some delegations.

Besides calling for increased health R&D investments, the resolution requests the regional WHO committees to discuss the CEWG report at their 2012 meetings and requests the Director General to hold an open-ended Member States meeting to analyse the feasibility of the recommendations contained in the report.

The adopted resolution text was developed by a drafting group established during the WHA to work on several proposed drafts submitted by a number of delegations and country groups: 1) Kenya; 2) Switzerland; 3) Union of South American Nations (UNASUR); 4) Australia, Canada, Japan, Monaco and USA.

The draft by Kenya suggested a ‘WHO Convention’ on R&D financing and coordination, while that of UNASUR suggested a ‘binding agreement’. The other two resolutions shared an operational paragraph on analysing the feasibility of CEWG recommendations at national level, with no reference to a binding instrument.

Despite this reluctance from a relatively large number of countries to proceed towards a binding instrument, the resolution was considered a positive step in the view of Member States wishing to take this issue forward.

Paraguay speaking on behalf of UNASUR, noted that the report underlined the importance of the regional and national strategy to promote generic medicines and comprised a clear call for action for MS to act within a global framework.

Congo, speaking on behalf of the African Region, stated that most African countries are in favour of a legally binding instrument, and called for accelerating the process in order to relieve the suffering of African people. Congo emphasised the need of finding new ways for mobilising resources also from the private sector are needed.

Brazil highlighted the fact that enormous inequalities persist, and that technology is an opportunity, but if not adequately shared it can become a threat. “We have a moral obligation”, Brazil said.

Libya, speaking on behalf of EMRO, supported the draft proposal submitted by UNASUR, hoping that this will be the end of debate on this matter.

The USA said they did not support a binding mechanism on financing. The USA noted that many other countries were not prepared either. According to the USA, history does not suggest that a central mechanism would support innovation.

China said that intellectual property rights are not enough, and that developing countries lack effective health technologies, and supported the WHO in playing a leading role in health R&D by establishing a global finance and coordination mechanism in order to avoid duplication and confusion.

Japan, a cosponsor of one of the draft texts, said that some options in the report must be analysed in terms of feasibility and financial implications. Japan also highlighted the need to combine technical cooperation, knowledge transfer and capacity building.

Switzerland, a proponent of one of the draft resolution texts, proposed consultations within and between countries, saying there is no clear vision yet for an instrument, be it binding or non-binding. Switzerland noted that opening negotiations towards a binding agreement now would be a risk.

Several public interest non-governmental organisations intervened on this issue. They noted that the patent system as the principal driver of pharmaceutical innovation has failed to deliver the medications needed for conditions faced in developing countries. They said the proposed instrument would give a material reality to the global moral obligation towards the poor.

NGOs expressed their concern to see certain reluctance among some Member States regarding the binding character of the proposed instrument. They called on Member States to adopt and implement the recommendations of the CEWG with all urgency and to ensure full transparency at all levels of this process.

Despite the absence of reference to a binding agreement on health R&D in the final resolution, the text was welcomed by all MS. The process and the will of the MS was commended.

Paraguay, speaking on behalf of UNASUR, appreciated the will of all Member States to achieve consensus and expressed its satisfaction towards the result.

Denmark, speaking on behalf of the EU, welcomed the outcome of the drafting group, and reaffirmed its support to the WHO Secretariat to find the most appropriate and cost effective sequence of solutions.

PHM pre debate comment

We commend the CEWG for its work and for maintaining a balanced and comprehensive approach, which is obvious in the elements it proposed and the recommendations put forward.

PHM supports working towards a binding instrument on health R&D focusing on diseases disproportionately affecting developing and least developed countries.

Reliance on the patent system as the principal driver for pharmaceutical innovation has left millions around this world without necessary medication. There is a need to materialise the global moral obligation towards the poor, knowing that they do not represent attractive markets for Big Pharma R&D undertakings.

For this reason, a binding instrument is a strategy worth pursuing.

Post debate comment

We are optimistic about this process; however, we were worried during the EB 130 (January 2012) to see some countries attempting to slow down the process. We sensed reluctance among some member states which may reflect the pressures of Big Pharma.

The WHO should ensure full transparency when undertaking this exercise. The setting up of committees and working group should be protected against vested interests of for-profit organisations. Identification of the different partners and non-State actors should be managed and overseen by Member States. We expect to see the principles articulated in the WHO Reform documents regarding conflict of interest being expressed in relation to the CEWG work (particularly because the very reason the CEWG now exists is an episode of corporate penetration of the WHO's supposedly independent processes).

Themes for advocacy

From a PHM perspective some of the main advocacy themes are:

- delinking the funding of innovation from the patent mechanism, at least for Type II and Type III diseases and for purposes associated with Type I diseases which are specific to L&MICs;
- pushing ahead with the proposed binding convention on research and development for Type II and III diseases and the associated resource mobilisation strategies.

13.15 WHO's role in humanitarian emergencies

The issues before the Assembly

The Assembly had before it a report from the Secretariat on WHO's role as the health cluster lead in humanitarian emergencies ([Doc A65/25](#)) and was invited to adopt the resolution [EB130.R14](#) forwarded by the EB.

The report provides the background (disasters, WHO's mandate, WHO's role within the UN system; the role of Cluster Lead within the UN system) some of the challenges experienced by WHO in responding effectively to humanitarian emergencies; and some suggestions about improving WHO's performance.

The resolution set out some principles; called for more funding and would mandate the DG to undertake a number of steps required to improve WHO's performance.

The debate

All Member States agreed with the document 'Strengthening WHO response to humanitarian emergencies' reaffirming the importance of the leading role of WHO as part of Inter-Agency Standing Committee in the Global Health Cluster. The main outcomes of the discussion were that the WHO needs:

- to become faster, more effective and more predictable in delivering high-quality action, with clear benchmarks for measuring performance;
- to develop a new, cross-organizational approach to improve the speed, consistency and predictability of WHO's response to both humanitarian and public health emergencies;
- a clear statement of WHO core commitments in acute emergencies, for which the Organization will be accountable, emphasizing the Organization's central role in respect to partner coordination, expert policy and technical advice, information, and communicable disease surveillance and control;
- further investments for the full application of a new WHO corporate approach to emergencies.

At the end of the discussion the Secretariat declared that it shared the same concerns as Member States affirming that the framework document still has to be finalized, accountability has to increase, the gaps in policies and process must be addressed and a key part of the reform will focus on country outcomes. AFRO also expressed concern for the difficulty of consensus building among all the humanitarian actors working in the region causing loss of effectiveness.

The resolution was finally approved as amended

PHM comment

WHO has focused on twin objectives: to build national capacities for emergency and disaster risk- management and integrate the latter into national health policies, strategies and plans; and to support acute and protracted emergency response activities.

One of the big challenges in emergency disaster relief is the lack of accountability of NGO humanitarian actors. This is not addressed in the resolution.

Another key issue is the involvement of affected populations in managing the disaster response rather than being displaced by fly in fly out ex-patriates. This has not been addressed in the report.

We appreciate the call for member states to “ensure that humanitarian activities are carried out in consultation with the country concerned, for an efficient response to the humanitarian needs, and to encourage all humanitarian partners, including nongovernmental organizations, to participate actively in the health cluster coordination and urge WHO to increase efforts in this regard”.

However, it is concerning that the “Organization’s structure does not allow it to implement major field-level operations, particularly for the direct delivery of life-saving interventions” in nations still lacking basic infrastructure to respond to emergencies.

We stress the need for a humanitarianism that goes beyond the relief of human suffering to include the prevention human suffering. This includes not only strengthening of national capacity and building resilient health systems, but also addressing the root causes of conflict and ensuring sustainable development.

About WHO Watch

The power relations around global decisions which shape population health can be changed through new alliances and information flows. The Democratising Global Health Governance Initiative (DGHGI) is designed to contribute to improved population health (and health equity) through new alliances and information flows. The Democratising Global Health Governance Initiative is a project of the People's Health Movement, in association with Third World Network, World Council of Churches, Medicus Mundi, Medico International, Health Action International, Cordaid and the Geneva NGO Forum for Health.

The structures and dynamics of Global Health Governance (GHG) are dominated by the big powers (in particular, USA and Europe) and by large transnational pharmaceutical corporations. The big players operate through the UN system, the Bretton Woods system and a plethora of global public private partnerships. They also operate directly through bilateral and regional trade agreements; through the operations of bilateral health-related assistance; and through direct advice and pressure. The operating paradigm of this regime is strongly influenced by the ideology of neoliberalism which is promoted through a much wider range of channels including the commercial media and various corporate peak bodies (such as at the World Economic Forum). In many respects the regulatory, financing and policy outcomes of this system reflect the interests of the rich world. This bias is reflected in:

- continuing unimpeded brain drain, in part because the rich countries do not train enough of their own professionals (it is much cheaper to import professionals trained in the developing countries);
- an intellectual property rights regime which is largely focused on maintaining the profits of transnational pharmaceutical companies and discounts the urgent need of millions of people in developing countries for affordable medicines;
- trade policies which sanction the dumping of agricultural produce on developing country markets (which jeopardises the livelihoods of small farmers);
- trade policies which pressure developing countries to cut tariff protection and export duties without regard to the consequent unemployment and loss of government revenues (and public services);
- health system policy models which are oriented to stratified health care delivery with private care for the rich, social insurance for the middle and safety nets for the poor;
- resistance to the kinds of sectoral policies suggested by the WHO Commission on the Social Determinants of Health which could greatly improve population health.

Low and middle income countries are largely excluded from the corridors and forums in which the decisions and policies of the prevailing regime of GHG are formed. Even outside the corridors and forums the voices of most low and middle income countries are muted and dispersed. There are important exceptions; a small number of L&MICs have invested significantly in their intersectoral work (eg between health and trade) and in global health policy advocacy. There are also resources within civil society globally which are well informed and supported by high level analysis and which are sympathetic to the perspectives

of L&MICs. Civil society networks which link North and South constituencies also provide an avenue through which the health needs of L&MICs can be brought to Northern consciousness.

There is a strong case for new alliances; for policy research and capacity building with a view to changing in some degree the perspectives which inform GHG and the balance of forces which shape such decision-making.

WHO Watch

WHO Watch is a project of the Democratising GHG Initiative. It is a resource for advocacy and mobilisation and an intervention in global health governance. As a resource for advocacy and mobilisation WHO Watch provides a current account of global policy dynamics in relation to a wide and growing range of health issues. While the focus is on issues being considered through the WHO the background documentation provides a more broadly based account of these issues. We aim to strengthen various streams in the Health for All movement (IP and access, trade and health, health systems, PHC, quality use of medicines, etc) by ensuring that activists whose concerns arise from their grass roots involvements can learn about the global dimensions of the problems they are facing and reshape their advocacy and mobilising accordingly.

WHO Watch is also an intervention in global health governance. Partly this is about defending WHO which has been subject to very bad stresses for several decades. WHO is the paramount health authority at the global level and needs to be strengthened and reformed and properly funded to play this role. WHO Watch seeks to generate support for a reformed WHO, restored to its proper place in global health governance.

WHO Watch also aims to democratise the decision making within WHO, in particular supporting delegations from smaller countries who are seeking to know more about particular issues or are looking for resources regarding issues that they are concerned about. Many delegates from small countries are over-stretched trying to cover a very wide range of issues. We are creating a resource which delegates to WHO governing bodies can turn to for analyses and policy options. Our objective in resourcing this constituency is largely about better decision making in WHO.

Finally, WHO Watch aims to support wider knowledge of, and participation in, the various engagements across the broader field of GHG. We are aiming to change the balance of power framing global decisions which impact on health.

Components of WHO Watch

There are several components of WHO Watch:

- watching (includes documentation, analysis and advocacy) at the governing bodies meetings in Geneva;
- watching (documentation, analysis and advocacy) at the regional committee meetings;
- watching (monitoring, liaison, collaboration, advocacy) with WHO country representatives;

- liaison with national representatives before their participation at the WHA, EB and regional committee meetings;
- maintenance and development of WHO Watch website providing accessible, high value policy analysis and a portal to other relevant resources;
- collaboration with other CSOs who are involved in health-relevant watching in relation to WHO and other international organisations.

EB Watch and WHA Watch involve mobilising young health activists (including [IPHU](#) alumni) from around the world (particularly from LMICs) to come to Geneva in January and May to monitor, document, analyse and advocate around the issues being discussed at the Executive Board and the WHA. The Watching includes an orientation workshop before the commencement of the meeting to review the wider GHG picture, the contemporary standing of WHO (and relevant background) and to explore in depth the agenda items. The watching includes documenting the discussion, nightly analyses, statements from the floor, and liaison with the many other CSOs attending. Watchers are encouraged to liaise directly with official delegates. In a final workshop watchers put together the implications for the various issues in the form of an advocacy resource for PHM at all levels (this report).

Watching the regional committee meetings involves applying the same principles and protocols at the regional level. It is complicated by the variations in protocols for CS recognition and attendance between different regional offices of WHO. Watching at the country level varies widely according to the different situations within countries and local regions. Ideally it involves building collaborative relations between CS and WHO representatives and ministers. In some cases it involves more of a monitoring and advocacy approach.

The [WHO Watch website](#) aims to document current movements in global health policy in terms of events, topics and at the regional offices. One of the objectives of the website is to provide a resource for delegates from countries which have limited policy resources in their own MOHs. (The WHO Watch website is quite complex because it seeks to track both the topics and events and regions. ‘Events’ refers to meetings of the governing bodies and includes further pages dealing with agenda items dealt with at those events. While the agenda item pages are specific to the considerations in focus at each particular event, the topic pages are designed to provide more stable references to the issues at stake. There is a lot of material on this site; users may find it productive to spend some minutes browsing the main departments to get a sense of its structure. The website is, and will remain, a work in progress.)

Critical to the work of WHO Watch are the links created between the watching processes and the various struggles for health in districts, states and provinces and countries. These links enable local activists to keep in touch with the global policy movements which shape the context for such local struggles. These links also help to ensure that policy analysis and policy advocacy at the regional and global levels is informed by the reality of grass roots activism, both in health systems and around the conditions which shape health.

WHO Watch acknowledges the dedicated work of the growing body of volunteer watchers and policy analysts and is grateful for the support of its funding partners.