

# People's Health Movement

## Background and Commentary on Items coming before EB144, January 2019

This analysis and commentary on items coming before the WHO Executive Board in Jan 2019 has been prepared by the People's Health Movement as a contribution to WHO Watch, a civil society initiative directed to the democratisation of global health governance ([more about WHO Watch](#)).

This PDF version of the PHM Analysis and Commentary is taken from PHM's [who-track.phmovement.org](http://who-track.phmovement.org) website.

Comment and feedback is welcome. Write to [globalsecretariat@phmovement.org](mailto:globalsecretariat@phmovement.org).

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## 5.1 Proposed Programme Budget 2020-21

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### In focus

Following review and discussion by the regional committees, a revised draft of the Proposed programme budget 2020–2021 is presented for consideration by the Board in [EB144/5](#).

In May 2018, the Seventy-first World Health Assembly considered a report from the Executive Board's Programme, Budget and Administration Committee ([A71/46](#)), which discussed a financial estimate for the Thirteenth General Programme of Work, 2019–2023 (contained in [EBPBAC28/5](#)). [EB144/6](#) provides an update on progress in implementing the action points for value for money contained in the financial estimate, together with information on the next steps in WHO's value for money strategy.

Pursuant to resolution [WHA71.1](#) (2018), in which the Executive Board requested the Director-General, inter alia, to use the [Thirteenth General Programme of Work](#) as the basis for the strategic direction of WHO's work during the period 2019–2023, [EB144/7](#) presents the Impact Framework providing the following: an overarching measure of healthy life expectancy; indices for each of the triple billion targets; and a set of programmatic targets.

### Background

The GPW

- [WHO's General Programme of Work](#)
- Tracker links to [previous discussions of PB18-19](#)

The investment case

- [Main page of the Investment Case](#)
- [The full investment case](#)
- [Background technical paper](#)

The transformation agenda

- [EB144/31](#) and new ways of working

Strategic budget space allocation

- See [EB136/35](#) and [EB137/6](#) which set out the approach to expenditure budgeting used in the development of WHO's PB;
- see [Tracker links](#) to the debate over strategic budget space allocation from 2014 - 2017

## Media coverage

- [WHO needs \\$14B — here's how it plans to raise it](#)

See also the summary reports of regional committee discussions of this item from paras 20-28 of [EB144/3](#).

## PHM Comment

### Public relations spin

WHO's budget documents are always slanted towards shaping perceptions but this [draft PB20-21](#) (and associated documents including [EB144/6](#) and [EB144/7](#)) may be more so than most.

The September '[Investment case](#)' and the investment language in the draft PB are directed to showing that donating to WHO is an investment in health (and economic) outcomes rather than simply an expenditure: "30 M lives saved; 100 M healthy years of life gained; 2-4% of economic growth in low and middle income countries". If only it were so easy!

The 'triple billion' slogan is quite good as marketing slogans go and the Investment Case is a slick product. However, the implicit assumption behind this kind of PR approach is that the obstacles to adequate funding of WHO are perceptions that WHO is not results-oriented, and not as well managed as it should be. ("This may have been true under Dr Chan but will not be so under Dr Tedros" - so the PR message is framed.)

The DG's 'value for money' strategy ([EB144/6](#)) is part of the PR offensive. The message is that while his predecessor might have neglected efficiency but Dr Tedros will give it close attention. Donors can be assured that they will get the biggest bang for their buck under the new administration.

This PR approach may well underestimate the sophistication and cynicism of the donor strategists. They know that the continued donor chokehold over the Organization is necessary to prevent the Secretariat from acting on resolutions which threaten the interests of the high income countries and their corporations. The criticisms of the Secretariat for not being results-focused or not well managed are largely a smokescreen to justify the continuing chokehold. If some sections of the Secretariat are more focused on process than outcomes it is in large part because of the distortions created by the competition for donor funding.

Dr Tedros's PR approach is not helped by the impenetrable managerial jargon in which much of the draft PB is written, eg:

- "align and build synergies in delivering the work of the three levels of the Organization" (para 2);

- “redesigning, optimizing and standardizing core WHO technical, business and external relations processes to meet best practices and allow harmonization across major offices in support of the Organization’s overall strategy” (para 17)

## Total funds

The draft PB envisages a marginal (8%) increase in total expenditure, in part through including provision for Emergency response (previously treated on an ad hoc basis) and in part through a provision for inflation.

The base component of the budget is projected to increase by 13% in part through including a portion of the polio budget in the base component reflecting the progressive mainstreaming of functions previously supported under the polio eradication campaign. The proposed budget also includes provision for increased funding for country offices and increased funding for ‘data and innovation’ (largely funded through ‘efficiency savings’ in Geneva). Finally there is provision to pay the UN levy to support the strengthening of the resident coordinator system and a contribution to the UN Sustainable Development Group.

## The donor chokehold remains in place

Para 73: “... all increases in the budget are to be met through voluntary contributions, for which ambitious targets will be set. As a result, there will be no request to increase assessed contributions for the Proposed programme budget”.

Tight earmarking of the bulk of voluntary contributions is expected to continue (Table 9) which in effect means that the donors are in a place to determine WHO’s priorities.

## New ways of working

The draft PB (and the GPW13 before it) makes a strong point about new ways of working. Some of this is just PR. However there are some features of this draft PB which may represent significant changes in Secretariat practice. These include:

- the increased country focus, including the country support plans,
- the invigorated Resident Coordinator role being introduced as part of the UN Development System reform, and
- the new Impact Framework (see [below](#)).

## Increased country focus

The PB promises an increased focus on supporting countries in tackling ‘the triple billion’ challenge.

A significant increase in country office funding is projected (from 38% to 42.6% of the base component).

‘Country support plans are being introduced to provide a mechanism to help coordinate the work of all three levels of the Organization in relation to each country.

“Annex para 11 (p77). The development of country support plans is a new step introduced through the planning process. The country support plan is an instrument to define the action that the Secretariat will take at each level of the Organization to support country priorities, and how it will measure its results and the resources and capacities required at each level. This additional step in the process aims to align the work of the three levels of the Organization towards delivering impact at the country level.”

## UN Development System reform

Two features of the current program of the UN Development System reform which figure prominently in the ‘new ways of working’ are the invigorated Resident Coordinator role (to be funded through a levy on UN organizations such as WHO, see United Nations General Assembly resolution [72/279 \(2018\)](#)) and the revised UN Development Assistance Framework ([UNDAF](#)).

There may be some marginal gains in efficiency as a result of improved coordination across the UN agencies but it doesn’t appear that the improved coordination will extend to the fragmentation of ‘development assistance for health’ arising from the multiple vertical PPPs and bilateral donors involved.

## The ‘new results framework’

The proposed Impact Framework (depicted in Fig 1 but elaborated in more detail in [EB144/7](#)) specifies:

- a top level impact to be measured in terms of healthy life expectancy;
- four Strategic Priority Areas (the triple billions plus ‘a more effective and efficient WHO) to be measured through yet to be finalised indexes (more in [EB144/7](#));
- a series of three Outcomes for each of the four Strategic Priority Areas to be tracked through a total of 46 Targets; these Outcomes are to be co-produced by WHO, member states and ‘partners’; and
- 42 Outputs, reflecting WHO’s contribution to the Outcomes to be tracked at the country level through largely unspecified ‘qualitative and quantitative indicators’;

The Framework states that the Outcomes will be co-produced by the Secretariat, Member States and ‘partners’ (including other intergovernmental organizations, various global PPPs, ‘the private sector’ and civil society, etc). However, it will be difficult to interpret Outcome measures without any framework for accounting for the contributions of the other agents, beyond WHO. There is no reference to attribution as a principle in relation to evaluation (the word does not appear).

Information on how the Secretariat support will be tracked is provided for some of the outputs under the fourth strategic priority area (a more effective and efficient WHO) but not for the other priority areas. Presumably the missing tracking indicators will be included in the final version of the PB prepared for WHA72.

Some of the tracking indicators which are listed under this fourth priority area are a bit bizarre (eg under Output 4.2.1). Many of the tracking indicators proposed are of the

“number of countries which have ...” character. The validity and reliability of this type of indicator are weak.

## Indicator development

[EB144/7](#) describes the use of healthy life expectancy as the highest level indicator. It describes the development of composite indicators for UHC, for Health Protection and for a Healthier Population. It also provides a list of the 46 ‘programmatic targets and related indicators’ (depicted in Fig 1 of EB144/5 as indicators of ‘Outcomes’).

The UHC Index will be based on ‘service coverage’ (using a range of ‘tracer conditions’) and financial protection (catastrophic health expenditure and medical impoverishment). The Health Protection Index will be based on IHR implementation status and immunisation rates. The Healthier Population Index will be based on 19 health status indicators and expressed in terms of ‘lives touched’ or ‘lives improved’ (based on ‘DALYs averted’).

The UHC Index has moved away from the three dimensional health care financing box in [WHR 2010](#) which depicted UHC in terms of the proportion of the population covered, the proportion of services covered, and the proportion of costs covered.

It is disappointing that the indicators which will go into the Healthier Populations Index are largely behavioural and proximal risk factors. There is little here to measure the more distal determinants of health as elaborated in the report of the Commission on the Social Determinants of Health.

It appears that while the UHC and Health Protection Indexes are status measures, so progress will be estimated in terms of improvements in these indexes, the Healthier Populations Index is itself an annual achievement measure.

The value added through the creation of these three high level composite indexes is debatable, except that having adopted the triple billion slogan in GPW13 the DG was obliged to demonstrate that he would be measuring it.

## Substantive programmatic commentary

The Implementation Overview provides commentary at each level from the four strategic priority areas, to the Outcomes (co-produced as noted above), to the Outputs (delivered by the Secretariat).

The high level commentary on the ‘four Strategic Priority Areas’, and the ‘Outcomes’ identified under those areas, is thin. It says little or nothing about the broader context which will shape the achievement of the Outcomes or about the contribution to those Outcomes expected of Member States (separately from WHO) or ‘Partners’.

This is a weakness in relation to the 46 Targets for the Outcomes since some capacity for attribution (what or whose intervention contributed in what degree to what outcome?) is necessary for evaluating WHO’s performance and learning how to do it better.

The commentary regarding Outputs and how the Secretariat will deliver is more useful and will provide a framework for Secretariat staff from different levels to work more closely

together (although much of the Output commentary reflects existing practice within existing programs).

## 5.2 Public health preparedness and response: Report of the Independent Oversight and Advisory Committee for the WHO Health Emergencies Programme

### Contents

- [In focus](#)
- [Background](#)
- [PHM Comment](#)

### In focus

[EB144/8](#) conveys the fifth report of the IOAC for the WHO Health Emergencies Programme to the governing bodies. The report provides the Committee's observations and recommendations based on its review of WHO's work in major outbreaks and other health emergencies during the period May–December 2018.

### Background

See [WHE Program webpage](#) and the [Q&A page](#) regarding the program.

WHO's [Emergency Response Framework \(2017\)](#) provides more useful detail.

See also the Five Year Global Strategic Plan for IHR capacity building ([A71/8](#)) and endorsed in [WHA71\(15\)](#).

See also the R&D blueprint ([A70/10](#) and [A71/6](#)).

See [Tracker links](#) to previous discussions of WHO's Health Emergencies Program including PHM comments.

### PHM Comment

The IOAC report is quite positive. It describes significant improvement in the capacity and performance of the WHO Health Emergencies Program and of the Secretariat more generally. The IOAC offers a range of practical recommendations to build on what has been achieved.

PHM congratulates the staff and leadership of the Program on what has been built in a relatively short time. In particular PHM appreciates the professionalism of WHO staff, and personnel associated with other partners, for their work in preparedness and response.

### IHRs

It is evident that many MSs are still lukewarm regarding their commitment to the IHRs. The IOAC reports that 86 countries have undertaken Joint External Evaluations (JEE) but only 38 National Action Plans for Health Security have been completed.

Many L&MICs see the high standards required by the IHRs as serving a 'global health security' agenda which may be a higher priority (relative to other priorities) for the rich countries than for the poorer ones. An appropriate response to this concern would be the transfer of additional resources from the rich donor countries to the countries of the South to enable full implementation.

#### Put a fence at the top of the cliff

The IOAC notes the links between IHR core capacities and health systems strengthening. However, the Committee does not mention the importance of WASH infrastructure in relation to prevention to infectious disease hazards or housing and transport infrastructure in relation to a range of other disasters.

Nor does the Committee mention the economic and geopolitical dynamics which contribute to the incidence and severity of emergencies. This latter issue was well described by Sanders, Sengupta and Scott (2015). "Ebola epidemic exposes the pathology of the global economic and political system." *International Journal of Health Services* 45(4): 643-656.

PHM calls on MSs to put in place a systematic capacity to document and analyse the upstream factors which contribute to health emergencies. Put a fence at the top of the cliff.

## 5.3 Polio

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- [Background](#)
- [PHM Comment](#)

### In focus

#### Eradication

Document [EB144/9](#) provides a status update on polio eradication, summarizing programmatic, epidemiological and financial challenges to securing a lasting polio-free world, and proposes a new strategic plan to achieve global certification by 2023, taking into account the fact that circulation of wild poliovirus has not yet been interrupted. The report provides:

- an update on the development of a strategy to extend the Endgame Plan to 2019-23;
- an overview of the current prevalence of wild type (Nigeria, Afghanistan, Pakistan) and vaccine-derived (DRC, Kenya, Somalia, Niger, Nigeria, Syria and Papua New Guinea) poliovirus;
- mention of [concern expressed](#) by the Emergency Committee under the IHRs of the fact that the declaration of the international spread of polio as a public health emergency of international concern has lasted for four years;
- an overview of progress in the phased removal of oral polio vaccines;
- a report on progress regarding containment which had been a focus of discussion at WHA71 (Item 12.9);
- a report on financing of the GPEI.

#### Transition

Document [EB144/10](#) provides a status update on the implementation of the strategic action plan on Polio Transition ([A71/9](#)), which was noted by the Seventy-first World Health Assembly in May 2018. The report:

- describes Secretariat activities directed to developing national transition plans;
- refers to the transition of polio assets into other programmes;
- describes the outcomes of the high level meeting called in late 2018 to discuss implementation of the transition plan and the governance of the Polio Post-certification Strategy; which highlighted the need to
  - design transition planning on a country by country basis;
  - sort out the confusion arising from the inclusion of transition functions in WHO's base budget (with fund-raising implications) and the extension of the GPEI for a further five years;
- describes planned activities for 2019 including
  - further country visits and work on national transition plans;

- a further high level stakeholders meeting to consider pragmatic and funding implications of transition, including
  - integrated vaccine-preventable disease surveillance,
  - strengthening essential immunization,
  - outbreak emergency response, and
  - containment
- further consultations on the 'future governance of polio transition' (after the GPEI);
- the development of communications and advocacy materials;
- the development of monitoring arrangements regarding polio transition.

## **Background**

See [Tracker links](#) to previous discussions of Polio and various documents, resolutions and decisions.

## **PHM Comment**

Eradication (wild type 1 and vaccine derived types) does not seem closer. It is self-evident that continued prevalence of paralytic polio is a function of conflict, war, displacement, fragile states, etc. The five year extension of the GPEI and the proposed extension of the Endgame Plan suggests something of a stalemate.

The continued financing of eradication activities as well as transition planning is now complicated by the apparent duplication of functions between WHO and the GPEI.

It appears that there are significant shortfalls in the development of national transition plans and fund-raising for such plans where domestic funding is not available remains uncertain.

EB144/10 notes that 'Options for the future governance of polio transition are a key issue for discussion, with a range of models put forward for consideration' (para 13).

Facility related containment remains problematic (see discussion of containment under [item 12.9](#) at WHA71).

See [PHM comment](#) at WHA71 regarding the longer range issues in global health governance and global health policy making arising from the commitment to polio eradication.

## 5.4 Implementation of the 2030 Agenda for Sustainable Development

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- [In focus](#)
- [Background](#)
- [PHM Comment](#)

### In focus

In [EB144/1 \(annotated\)](#) the Secretariat advises that:

*In line with resolution [WHA69.11](#) (2016) the Director-General submits a report on attainment of the health-related Sustainable Development Goals ([EB144/11](#)). Part I of the report summarizes global and regional progress made by Member States towards achieving Goal 3 (Ensure healthy lives and promote well-being for all at all ages), as well as other health-related goals and targets. Part II describes progress made in implementing resolution [WHA69.11](#).*

### Background

See the [2030 Agenda for Sustainable Development](#) as adopted by the UNGA.

See also the Tracker index to [recent discussions](#) of SDGs at WHO's global governing bodies.

Much in our previous commentaries on the SDGs remains relevant. See:

- [PHM comment on Item 31.2 at WHA69](#)
- [PHM comment on Item 16.1 at WHA70](#)

Two of the chapters in the current Global Health Watch<sup>1</sup> also carry powerful criticisms of the SDGs:

- A1: [Sustainable Development Goals in the age of Neoliberalism](#)
- A2: [‘Leave No One Behind’ — are SDGs the way forward?](#)

These short chapters deserve to be more widely read. Here we just refer to a few of the key arguments developed in GHW5 A1:

SDG8 proposes that the cost of meeting the rest of the goals will be met through 'sustained per capita economic growth'. GHW comments that the assumed metric, GDP, is a measure of market transactions regardless of their contribution to ecological sustainability or human development (or health). Manufacturing and deploying weapons of mass destruction makes a powerful contribution to GDP.

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<sup>1</sup> GHW5 was the last in the series to be edited by the late Dr Amit Sengupta who was an outstanding activist / commentator on the political economy of health globally, including the significance of the SDGs in relation to the neoliberal project.

SDG8 calls for full employment (Target 8.5) and for 'higher levels of economic productivity' ('increase in real GDP per employed person'). This combination of targets ignores the role of productivity increases (as measured) in creating unemployment! Conventional economic theory assumes that the labour displaced by increased productivity will simply be re-employed in new forms of better-paying work. What such theory disregards is the massive displacement of agricultural labour from 'increased productivity' and the huge mobilisation of Third World workers (displaced from agriculture) in global manufacturing: "too many workers competing for too few jobs to produce too many goods or services for too few consumers with too little income to afford them without increasing their already high levels of personal debt".

GHW5 also comments on the continuing call for increased 'development assistance' as a key pathway to funding the SDGs. This strategy has failed to impact on sustainable development over several decades even while fragmenting health systems and placing huge administrative burdens of governments. Meanwhile no action is proposed on tax evasion through transfer pricing and tax havens nor on the pressures of tax competition and corporate tax extortion which have held back tax revenues and public spending.

GHW5 also comments on principle of reciprocity (non-discrimination) in the current regime of trade agreements; a principle which treats poor countries the same as rich countries despite massive differences in economic and political power. The New International Economic Order, which features in the Alma-Ata Declaration (and is notably missing from the 2018 Astana Declaration), envisaged discrimination in favour of developing countries to be structured into a rules based trading regime. Not only are modern trade agreements non-discriminatory (in the sense of including few or no provisions for 'special and differential treatment') but they discriminate blatantly in favour of the rich countries through extreme IP provisions, regulatory harmonisation and investor protection.

GHW5 also addresses the difficult topic of population control. It is established that family sizes fall with economic development and the provision of social protection. However as population levels level or fall in the rich countries the call is increasingly heard for encouragement for population growth through fertility and (selective) immigration. GHW5 labels this as a Ponzi population policy:

*Its argument is that, with population aging, immigration and/or incentives for larger families should be encouraged to re-swell a comparatively shrinking working age cohort (those between 15 and 64 years). The economic rationale is that the taxes collected from the productivity of the working age population is needed to pay for the services and pensions of a proportionately greater and increasing number of elderly. That makes sense, perhaps, for the short-term. But fast forward 40 or 50 years, and the re-swelled working age cohort has itself become elderly (and far more numerous), requiring an ever larger expansion in the base of the working age population. And so on, and on, and on.*

GHW5 A1 should be compulsory reading in preparation for the debate on EB144 Item 5.4.

## PHM Comment

Part I of EB144/11 is a burning indictment of the prevailing global governance regime. It needs to be read far more widely than just within WHO. Health science students and practitioners should read this and ask why?

Various reports including the [SDG Index and Dashboard](#) report show that no country is on track to achieve health related SDGs by 2030. PHM urges WHO to jointly review progress at the country level annually and report to the Assembly on how countries can plan and act to ensure that no one is left behind.

Part II seeks to present a positive spin on the relevance, to the SDGs, of a range of WHO programs, projects and engagements. Many of these are admirable initiatives and WHO staff are to be congratulated for their commitment and achievement. However, WHO works under two major constraints which must be named.

The first is WHO's financial crisis imposed through the donor chokehold and the freeze on mandatory contributions. We comment in more detail on this under Item 8.1 ([here](#)).

The second constraint is imposed by the norms of diplomacy. WHO (including MS delegates and staff) are supposed to restrict their comment to an imagined domain of 'public health' ('normative' and 'technical') and avoid reference to the wider dynamics of inequality, economic instability, climate crisis and population growth and to the structures and forces which are driving these dynamics.

Governments are increasingly constrained by corporate extortion, the disciplines of 'the markets' (stock markets, currencies and exchange rates) and imperial bullying. In these circumstances civil society activism is a basic necessity for rolling back neoliberalism and taming globalised capitalism.

One of the most powerful weapons of such activism is 'delegitimation', denying the legitimacy of the prevailing regime. Delegitimizing the myths of the SDGs (see [GHW5 A1](#)) requires that we transgress the niceties of diplomatic norms.

PHM urges member state delegates to speak truth to power at the Executive Board.

PHM urges health activists around the world to raise public awareness and lobby their governments around the disaster that is looming behind the language of 'sustainable development'. Key talking points in such advocacy include:

- insist on naming liberalised transnational capitalism as a failed economic system (driving widening inequality, deepening the imbalances between productive capacity and consumption, increasing financial fragility and deepening our peonage to the banks through increasing debt);
- insist on naming neoliberalism as a policy package (austerity, small government, privatisation, tax competition and corporate privilege) being implemented in order to protect the transnational corporations and preserve the privileges of the transnational capitalist elite;
- recognise the contradictions between the neoliberal program on the one hand and the goals of reducing poverty, promoting Health for All, and mitigating climate change on the other;

- reject the bizarre assumption that the SDGs can be paid for through increased economic growth (as measured by GDP) without attention to the harms or benefits of the market transactions so measured;
- insist on the need for a New International Economic Order as called for in the 1978 [Alma-Ata Declaration](#) (and completely ignored in the October 2018 [Astana Declaration](#));
- insist on naming the xenophobic backlash, and the populist demagoguery which is stoking it, as barriers to effective action on the SDGs; and
- continue to denounce the restrictions imposed on WHO's capacity and its voice by the donor chokehold and the ACs freeze.

These issues are all strikingly absent from EB144/11.

See "Big Business Capturing UN SDG Agenda?" by Jomo Kwame Sundaram and Anis Chowdhury ([here](#)).

## 5.5 UHC

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### In focus

There are three sub-items included under this item:

- Primary health care towards universal health coverage;
- Community health workers delivering primary health care: opportunities and challenges; and
- Preparation for the high-level meeting of the United Nations General Assembly on universal health coverage.

Primary health care towards universal health coverage (EB144/12)

Forty years after the [Declaration of Alma-Ata in 1978](#) the Global Conference on Primary Health Care convened in Astana, Kazakhstan in October 2018 and produced the [Astana Declaration](#).

[EB144/12](#), prepared by the DG for this subitem:

- notes the agreements and commitments enshrined in the [Astana Declaration](#);
- briefly reviews contemporary health and health system challenges;
- refers to several key documents prepared by WHO & UNICEF as inputs to the Astana Conference:
  - [A Vision for primary health care in the 21st century](#);
  - [Primary health care: transforming vision into action: Operational Framework](#);
  - [Background documents](#): an index page linking to
    - the Vision and the Operational Framework,
    - a set of documents on the *Case for PHC* (of which only one, [the Economic case](#)) is presently published, and
    - a series of documents on several of the 'operational levers' included in the Operational Framework;
- refers to the [Global Action Plan for healthy lives and well-being for all](#) (a joint initiative of 11 global health organisations and structured around achieving the SDGs and especially the Health goals); see in particular the [mapping document](#) and the [accelerator documents](#);
- refers briefly to [EB144/13](#) on community health workers; and
- refers to the decision of the UN General Assembly (UNGA) to hold a high-level meeting on universal health coverage in 2019 (discussed in more detail in [EB144/14](#)).

In [EB144/12](#) the DG invites the EB to focus its discussions on:

- consideration of the Declaration of Astana, including its potential role in reorienting health systems around primary health care in Member States;
- the process for taking into consideration the commitments of the Declaration of Astana in the preparations for the forthcoming high-level meeting on universal health coverage;
- the interlinkages between reforms in primary health care and development of the health workforce, including community health workers and all other relevant cadres according to context.

It appears that the DG is looking for endorsement of the [Vision](#) and the [Operating Framework](#) documents (as modified) and a mandate to develop materials for the HLM of the UNGA on UHC which:

- feature PHC (as per the Vision and the Framework) as necessary for the achievement of both UHC and the SDGs;
- align the materials prepared for the HLM with the [mapping](#) and 'accelerator frames' developed for the Global Action Plan for healthy lives and well-being for all; and which
- features workforce development (and in particular community health workers) as a critical component of this package.

### Community health workers delivering primary health care: opportunities and challenges (EB144/13)

In the Declaration of Astana (Kazakhstan, October 2018) Heads of State and Government committed themselves to investing in the primary health care workforce in order to accelerate progress towards universal health coverage.

[EB144/13](#) focuses on the education and deployment of community health workers within the primary health care team. The report is based on a new [WHO guideline](#) that examines opportunities and challenges for the successful education, remuneration, deployment and supervision of community health workers. (See also [an abridged version of the guideline](#) in Lancet Global Health.)

Document [EB144/13](#):

- starts with generalities about workforce development and the status of CHWs in the wider workforce context;
- comments on the problems of evidence and lists some common shortcomings in CHW programs;
- lists 6 key principles which should be realised in CHW programs;
- lists 7 policy recommendations (selection, certification, supervision, compensation, entitlements, career development, service delivery models);
- lists key actions for the design and implementation of CHW program:
  - at the national level, and
  - for international organisations (donors and IGOs).

In [EB144/13](#) the DG invites the EB to note the report. The DG suggests that the Board might wish to focus on:

- the contribution of community health workers to primary health care and the achievement of universal health care;

- the importance of integrating community health worker programmes in the broader policies on health workforce and health system development; and
- the need to factor in the national planning and resource allocation processes the corresponding governance, management and financing implications.

As a guideline there is no immediate requirement for governing body endorsement (although the governing bodies may choose to dissociate themselves from guidelines). Para 17 of [EB144/13](#) notes that the Secretariat has commenced dissemination of the Guideline. The Board may choose to simply note the report, effectively endorsing continued dissemination. Or the Board may more actively endorse the report with a resolution or a decision. Or there may be MSs who would wish the Board to dissociate itself from the Guideline.

There is no reference to the HLM of the UNGA in [EB144/13](#). However, given the context in which the Guideline is presented it seems likely that the DG is looking for a mandate to include reference to CHWs (and the principles and recommendations listed in [EB144/13](#)) in the materials prepared for the HLM.

### Preparation for the high-level meeting of the United Nations General Assembly on universal health coverage (EB144/14)

In 2017, the United Nations General Assembly decided in [Resolution 72/139](#) to hold a high-level meeting on universal health coverage in 2019 and requested WHO to collaborate closely with the President of the General Assembly, in consultation with Member States, to ensure the most effective and efficient outcomes.

Document [EB144/14](#) reports on the Secretariat's preparations to date and seeks guidance on next steps. [EB144/14](#):

- notes recent statistics regarding financial barriers to health care and notes the limitations of disease oriented programs;
- notes the inclusion of UHC in the SDGs;
- reviews indicative data regarding service coverage;
- overviews recent data on catastrophic health expenditure and health care impoverishment;
- reviews the scope, modalities, format and organisation of the proposed HLM; and
- reflects on the possible themes of the Political Declaration and on the process through which it will be developed.

The EB is invited to note the report and provide further guidance regarding the development of the Political Declaration.

It might be that the DG is seeking the endorsement of the EB for focusing on PHC and CHWs in the development of the Political Declaration.

## Background

The [Declaration of Astana](#) comprises a general vision statement; an affirmation of rights and needs; a commitment to making bold choices and building sustainable primary health care; and a recognition of key drivers for successful implementation of PHC.

The [Civil Society Astana Statement on Primary Health Care](#) provides a useful alternative perspective on PHC.

The [Vision document](#), produced by WHO and UNICEF (but not explicitly endorsed by the Astana Conference):

- provides three reasons why a focus on PHC is critical at this time (adapting to complexity, effective and efficient, a prerequisite for UHC and the health SDGs);
- presents PHC in terms of three basic components (primary care and public health, intersectoral action, and empowering individuals, families and communities);
- summarises a series of three 'governance, policy and finance' levers and 10 'operational' levers which are presented in more detail in the [Operational framework](#) and [Background documents](#).

The [Global Action Plan for healthy lives and well-being for all \(SDGs\)](#) was endorsed by 11 'global health organisations'. It [maps](#) the responsibilities and commitments of all 11 organisations in relation to the goals and targets of the 2030 Agenda for Sustainable Development and posits a number of 'accelerators' for driving the implementation of the Plan; these accelerators are explored in more detail in the draft [accelerator frames](#).

Note the intention of the Evaluation Office of WHO to undertake a review of 40 years of primary health care implementation at the country level in 2019. See [EB144/51](#), paras 15-20.

See [Tracker links](#) to previous discussions of PHC and UHC.

See [Tracker links](#) to previous discussions of HRH, including CHWs.

## **PHM Comment**

The material developed for and through the Astana conference ranges from the simple (the Declaration) to the complex (the details regarding the various 'levers'). There are some gaps in the material currently available and a number of typographical errors which suggest some haste in the development of the documents.

Nonetheless, PHM believes that the package as a whole represents a major step forward for WHO.

The construction of PHC is good. The three reasons make sense and the three components encapsulate in large degree the vision of Alma-Ata for a 21st Century context (see [Vision, p 14](#)).

However, PHM has two major criticisms of the new model of PHC articulated in these documents.

An element of the Alma-Ata Declaration which has been completely expunged in the Astana Declaration and the new documents before the Boards is the call for a new international economic order (NIEO).

Equitable economic and social development will require rejection of the currently dominant neoliberal paradigm and establishment of a sustainable and equitable economic order globally and nationally. Amongst other interventions regulation of financial flows and of tax

havens and evasion are urgently needed. These changes, along with recognition and action to address inequities due to gender, caste, race, disability and sexual orientation, are of basic importance to the fullest attainment of health for all and to the reduction of the gap in the health status within and between countries.

PHM calls on member states to remind the Secretariat of the history and significance of the call for a NIEO ([A/RES/S-6/3201](#), 1974) and the continuing need for a contemporary version of this call.

There is some confusion apparent in the documents regarding the relationship between PHC and UHC.

The International Advisory Group which was appointed to assist in the development of the strategy was entitled the International Advisory Group on Primary Health Care **for Universal Health Coverage** which suggests that UHC is somehow the ultimate goal and the PHC model is to be somehow harnessed towards that end.

This perspective is evident also in the passage:

*Put simply, now is a good time to both review and adapt the Alma-Ata Declaration and develop a new vision of primary health care (PHC) as a foundation of universal health coverage, for the SDG era and beyond. Vision page iv.*

However in the body of the Vision there are several passages which posit PHC as a prerequisite for the achievement of UHC:

*Universal health coverage (UHC) and the health-related sustainable development goals (SDGs) can only be sustainably achieved with a stronger emphasis on PHC.*

*UHC and the health-related SDGs can only be sustainably achieved with a stronger emphasis on PHC.*

*A new approach to primary health care is central to achieving the SDGs and UHC.*

The construction of PHC as a precondition for achievement of both UHC and the SDGs brings these different frameworks together with greater coherence than has been evident previously. (It is unfortunate that this sub-item is labelled as "Primary health care towards universal health coverage" which suggests that PHC is simply a means to an end, that end being UHC.

The proposition that the HLM of the UNGA which is ostensibly about UHC should be asked to endorse the principles developed in the Vision and the Operational Framework is bold. The proposed inclusion of PHC as one of the 'accelerators' in the Global Action Plan is also bold.

PHM calls on member states to commend the Secretariat for this new formulation of PHC as a necessary prerequisite for the achievement of UHC>

## Work in progress

The Infographic (which appears in both the Vision and the Operational Framework) cites three aspects of 'the case for PHC'. At this stage (31 Dec 2018) the Economic case is presented but the "health outcomes case" and the "responsiveness case" do not seem to have been published yet.

There are seven Accelerator Discussion Frames, under the Global Action Plan, linked from the [index page](#). All of these documents ('frames') are linked except for "Accelerator 2. Frontline health systems/Primary health care". Note that 'primary health care' has been added to the title of this frame since the [GAP](#) was first adopted (?March 2018) by the 11 organisations. It appears that the DG is seeking the agreement of his counterparts to give greater prominence to PHC as an 'accelerator'.

There are significant differences between the infographic, included in both the Vision and the Operational Framework, and the text of these two documents. Fifteen operational levers have been reduced to 10, largely through amalgamations. Multisectoral Action and Rural Health appear to have been dropped, as headings, and "Empowering individuals, families & communities" from the Infographic has been converted into "3.1 Engagement of community and other stakeholders to jointly define problems and solutions and prioritize actions". Note that "empower individuals and communities" is a heading in the Astana Declaration.

## Detail

There is a huge amount of detail in the material listed for consideration under this item (especially the 'levers' and 'accelerator frames'); far more than can be properly considered by the EB at one sitting. Clearly there will be a need for further consultation in the lead up to WHA72 in May.

However, there are some points of principle which should be highlighted in the EB debate.

- PHC as a pre-requisite for achieving UHC and the health-related SDGs makes much more sense than "PHC towards UHC" which has been the formulation up until now; the DG should be appreciated for this shift. PHC is so much more than UHC.
- The downgrading of intersectoral action in the Operational Levers is also reflected in the descriptive material regarding various 'levers' which shows a lack of practical understanding of how intersectoral action through PHC can take place. It is not clear why intersectoral action has been discounted, especially given that it is listed as one of the three core components of PHC.
- PHC is constructed as including three components, one of which is described in summary as "primary care and public health functions". However, in several of the Operational Levers there is much more about primary care than about public health functions. MS are urged to mention this weakness.
- "Integrating health services" and "Integrating public health & primary care" have been incorporated into "Models of care that prioritize primary care and public health functions as the core of integrated health services". "The role of the hospital" has been incorporated into "Physical infrastructure and appropriate medicines, products and technologies". There is a risk that with these changes the coordination and integration of primary, secondary and tertiary care will be discounted in particular,

program planning, technical support and the referral relationship. MS are urged to mention this issue.

### Problematic (more to come)

The discussion of private sector engagement in the Operational Levers is problematic ([vision here](#)). Of course it says everything, including mentioning risks, but the matrix of actions is dominated by private sector engagement rather than regulation and nothing about funding reform..

A high level of private sector involvement is inimical to PHC and the achievement of UHC in particular. UHC should be defined as universalist, based on social solidarity and built mainly on a unified public funded system, with most service provision through public institutions.

The implementation of public interest policy is much more difficult in a marketised health system with private sector dominance with consequent shortfalls in quality, effectiveness and efficiency. Overservicing and clustering of providers in high income suburbs are common. Partnerships with the private sector generally lead to private extraction of profits at the expense of public health.

“Strategic purchasing” has been converted into “Purchasing and payment systems”. This makes sense. PHM particularly appreciates the comments about replacing the ‘defined benefit package’, which is generally a reference to insurance, with a more comprehensive approach to financing PHC:

*At the community level, the delivery of predefined service packages focused on specific diseases has left large gaps in coverage, depriving the population of the significant benefits of comprehensive integrated community-informed and person-centred health services.*

*As health systems evolve, in line with each country’s technical and financial resources, packages of services aimed at dealing with specific health problems are progressively replaced by fully integrated, comprehensive, people-centred primary care.*

### Community health workers

PHM welcomes the focus on CHWs as part of the PHC team and supports in general terms the 6 key principles and 7 policy recommendations. However, we believe that a more extended discussion of the role that CHWs can play in addressing the social determinants of health, including through intersectoral liaison and through community mobilising. The function of CHWs can be much more than simply 'service providers'.

### Political Declaration

PHM urges MSs to support the inclusion of PHC (as a pre-requisite for UHC and the SDGs) and endorsement of the importance of CHWs (for PHC, UHC and the SDGs) in the Political Declaration.

PHM urges MSs to endorse the the [Vision](#) and the [Operating Framework](#) documents and to request the DG to continue working along the lines outlined

PHM urges the MSs to endorse the [mapping](#) and '[accelerator frames](#)' developed for the Global Action Plan for healthy lives and well-being for all and request the Secretariat to incorporate the principles developed into the Political Declaration.

## 5.6 Health, environment and climate change

### Contents

- [In focus](#)
- [Background](#)
- [PHM Comment](#)

### In focus

In line with decision [EB142\(5\)](#) (2018) the Board has two reports for its consideration.

Draft WHO global strategy on health, environment and climate change (EB144/15)

[EB144/15](#) presents a draft comprehensive global strategy on health, environment and climate change. The strategy presented in EB144/15 is supported by a more detailed [web annex](#). The Board is invited to note this report and provide further comments and guidance.

The draft global strategy commences with a Scoping statement, a review of The Challenge and a Vision statement.

It then outlines six Strategic Objectives around which the global strategy is framed:

1. Primary prevention: to scale up action on health determinants for health protection and improvement in the 2030 Agenda for Sustainable Development
2. Cross-sectoral action: to act on determinants of health in all policies and in all sectors
3. Strengthened health sector: to strengthen health sector leadership, governance and coordination roles
4. Building support: to build mechanisms for governance, and political and social support
5. Enhanced evidence and communication: to generate the evidence base on risks and solutions, and to efficiently communicate that information to guide choices and investments
6. Monitoring: to guide actions by monitoring progress towards the Sustainable Development Goals

The draft strategy then lists a number of Implementation Platforms

- An empowered health sector
- Stronger national and subnational platforms for cross-sectoral policy-making
- Key settings as sites for interventions (households, schools, workplaces, health care facilities, cities, etc)
- Partnerships for a social movement for healthier environments
- Multilateral environmental, health and development agreements (including platforms for the SDGs)
- Evidence and monitoring

The draft strategy then focuses on WHO's Role and Leadership in Global Health. This is summarised in [Figure 2](#) and discussed in relation to the three Strategic Priorities adopted in GPW13 (Healthier populations, Emergencies, UHC).

This section (on WHO's role) is supplemented by an extended [web annex](#) which:

- Lists a range of resolutions adopted by regional committees and the WHA which in aggregate provide the mandate for the draft global strategy;
- Lists the extant commitments arising from such resolutions in the areas of:
  - Water, sanitation, waste and hygiene,
  - Climate and ecosystem change,
  - Air pollution,
  - Chemical safety,
  - Occupational risks and working environment,
  - Radiation; and
- Lists the priority interventions in the key settings (in particular, cities and households);
- Lists initiatives targeted towards specific vulnerable groups.

The monitoring of progress in relation to the draft global strategy is based entirely on targets and indicators already adopted under the SDGs.

#### Draft global plan of action on climate change and health in small island developing States (EB144/16)

At the 23rd session of the Conference of the Parties to the UNFCCC in Bonn in October 2015 WHO launched a 'special initiative' on climate change and health in small island developing States (SIDS). This initiative was adopted into the [GPW13](#) as one of five 'platforms' from which GPW13 is to be implemented, in particular the Healthier Populations strategic priority area.

In 2018, the Executive Board adopted decision [EB142\(5\)](#) on health, environment and climate change in which the Director-General was requested to develop "a draft action plan for the platform to address the health effects of climate change initially in small island developing States".

[EB144/16](#) provides an update on progress made on this draft action plan. The Board is invited to consider the draft action plan and provide further guidance.

The draft global plan of action includes:

- Background, reviewing the key issues, summarising work in train and describing the process of developing this global plan;
- Vision, focusing explicitly on adaptation (but a stronger voice for SIDS in decision-making around mitigation is implied in the body of the plan);
- Scoping, identifying as within scope, WHO support to SIDS:
  - understanding and policies to address (adapt to) impacts of climate change on health;
  - health system strengthening in SIDS, including climate resilience, ecological sustainability, preventative orientation and closer integration across health programs;
  - to promote mitigation action within and beyond SIDS;
- Four 'strategic lines of action':

1. Empowerment: Supporting health leadership in small island developing States to engage nationally and internationally
    - 1.1. Establish at WHO a small island developing States hub or alternative coordination mechanism on small island developing States to provide support to climate change, environment and other priority health issues
    - 1.2. Provide health sector inputs to the United Nations Framework Convention on Climate Change and stakeholders leading relevant national climate change processes (e.g. national adaptation plans, national communications, nationally determined contributions)
  2. Evidence: Building the business case for investment
    - 2.1. In collaboration with the United Nations Framework Convention on Climate Change, develop or update national climate and health country profiles for every small island developing State
    - 2.2. Identify, support and build on existing centres of excellence for increasing capacity, conducting assessments, data analysis, research and implementation of actions, including with organizations and universities that have regional mandates
  3. Implementation: Preparedness for climate risks, adaptation, and health-promoting mitigation policies
    - 3.1. Support small island developing States through regional frameworks to build climate resilient health systems;
    - 3.2. Develop and implement programmes to raise awareness and build capacity for adaptation and disease prevention both by people and by the health system [in SIDS];
  4. Resources: Facilitating access to climate and health finance
    - 4.1. Lead a process to identify new and innovative forms of funding and resource mobilization mechanisms
    - 4.2. WHO will pursue the process to become an accredited agency for the Green Climate Fund and facilitate support to small island developing States
- Monitoring and reporting of progress

## Background

[Tracker links](#) to previous EB and WHA discussions of environment and climate change.

See also the summary reports of regional committee discussions of this item from paras 4-10 of [EB144/3](#).

## PHM Comment

Draft WHO global strategy on health, environment and climate change

This is an excellent draft global strategy. PHM urges member states to strongly support it. It is an excellent strategy but needs to be further strengthened before consideration at WHA72.

In relation to climate change the report needs to exhibit a greater degree of urgency, including reference to the findings of the IPCC special report on [“Global Warming of 1.5 °C”](#) (not mentioned in EB144/15).

Warming beyond 1.5C would be extremely dangerous for human health and we may exceed 1.5C in 12 or so years. The next decade will decide whether we stay below 1.5°, 2° or 3° C. The IPCC report should be a game-changer in the climate change debate. Whether it will be remains to be seen but WHO should be championing it extremely vigorously with this in mind.

The references in paras 3 and 4 to “natural environments that cannot reasonably be modified” is not explained in either EB144/15 or the web annex. There is no reference to the criteria for such a judgement nor are any examples offered. Short of sunspots, gamma ray bursts and volcanoes it humanity must accept a far reaching stewardship for the wellbeing of our earthly home.

The section in the web annex on vulnerable groups is clearly incomplete. There are no references in the annex to gender or to indigenous populations.

The [Global Strategy for Women’s, Children’s and Adolescents’ Health, \(2016–2030\)](#) highlights Water, sanitation and hygiene and Indoor air pollution as particular risks / exposures affecting women (page 21). Indoor air pollution was highlighted again in the Secretariat report ([A68/16](#)) on 20 years after the Beijing Declaration. [WHA60.25](#) adopted the Strategy for integrating gender analysis and actions into the work of WHO (presented in [A60/19](#)).

WHO’s mandate in relation to indigenous health appears to be thinner than with respect to women. A WHO [fact sheet](#), published in 2007, mentions poor sanitation and access to potable water. It does not mention the environmental health consequences of displacement of indigenous peoples through colonisation and the encroachments of agriculture, mining and deforestation. See also the [UN Declaration on the Rights of Indigenous Peoples](#).

Further consideration of indigenous peoples, in the development of the global strategy, would be of particular significance in view of the cultural challenges associated with “transforming our way of living, working, producing, consuming and governing” (from para 2 of the draft global strategy). Many indigenous peoples have traditional concepts of humans’ relationship to our environment which emphasise custodianship, harmony and the rights of Mother Earth and all who depend on her. Such concepts should not be beyond the scope of WHO. Article 2(l) of WHO’s Constitution establishes as one of WHO’s functions “to foster the ability to live harmoniously in a changing total environment”.

‘Buen vivir’ refers to a philosophy arising among the indigenous peoples of the Andes which has been seen by many as providing inspiration in relation to the transformations called for in the draft global strategy. See [Calisto Friant and Langmore \(2015\)](#). “The Buen Vivir: A Policy to Survive the Anthropocene?” *Global Policy* 6(1): 64-71.

The draft global strategy would be improved through a stronger consideration of the cultural challenges of ‘surviving the anthropocene’. One of these challenges concerns security and solidarity. Many instances from around the world demonstrate that when people are insecure (in relation to food, money, violence, etc) they are generally less open to the massive

changes in production and consumption that are necessary if humanity is to mitigate and adapt to climate change. Numerous instances also demonstrate the willingness of corporate executives and politicians to resist action on climate change because of risks to their power and wealth. These are in part issues of accountability (as implied in the draft global strategy) but they are also issues of culture.

Another area which is not discussed in the draft global strategy is funding of action on environmental health and climate change in the context of obscene inequalities in wealth (individual, national) globally. Reference is made to SDG13, to 'Double the amount of climate finance for health protection in low- and middle-income countries' but justice calls for more than charity. The global economy has been and is being structured, deliberately, to extend the rights of transnational corporations and to preserve the privileges of the already wealthy. Para 28, which calls for a social movement to drive political will, hints at an awareness of the wider political economy of action on climate change and other environmental crises.

Many of these dynamics are implied but unstated in the draft global strategy. This is understandable in terms of the realpolitik of WHO's governing bodies but it does weaken the message.

Funding is the critical vulnerability of this draft global strategy. Under the donor chokehold (frozen ACs and tied VCs) the DG has little discretion in funding programs like this one unless donors can be found who are willing to fund it.

PHM urges MS to support the draft global strategy, including ensuring sufficient funding. The planet cannot wait. However, as the strategy points out, the outcome will depend on "mobilizing public support for more sustainable and health-promoting development choices".

#### Draft global plan of action on climate change and health in small island developing states

This draft global plan of action appears to project a range of practical measures to progress the 'special initiative' launched at the Bonn COP in October 2015.

However the structure and language of much of the draft global plan is woolly and quite obscure in parts, especially under Action 1.2 and para 15 and under Line of action 3. It is not always clear whether the plan is talking about action by WHO or by health leaders in SIDS, or whether it is talking about action within or beyond SIDS.

The commitment to support health leaders in SIDS to promote national level understanding of the health dimensions of climate change and to gain leverage from the health issues in advocating for mitigation internationally is appreciated. However, while there is a reference to 'health-promoting mitigation policies' (which apparently means co-benefits) in the title of Strategic Line of Action 3 there is nothing in the body of this line about how it will be operationalised.

The reference in para 10 to "transforming health services in small island developing States away from a model of curative services with escalating costs and towards a model based on disease prevention, climate resilience and sustainability" could be interpreted as a blanket critique of health systems in SIDS. It could perhaps be reworded.

One element of adaptation of particular relevance for small island states is provision for orderly migration should it become necessary. While this is controversial the possibility of such a scenario needs to be recognised.

PHM urges MS to support the draft global plan of action but to ask the Secretariat to review and revise the structure and text of the plan in the lead up to WHA72 to ensure clearer communication of its intended purposes and actions.

## 5.7 Medicines, vaccines and health products

Two somewhat different issues are included under this item supported by different Secretariat documents. It is not known at this stage how the Board will structure the discussion of these sub-items. In this commentary the sub-items are considered separately.

### Contents

- [Access to medicines and vaccines \(EB144/17\)](#)
  - [In focus](#)
  - [Background](#)
  - [PHM Comment](#)
- [Cancer medicines \(EB144/18\)](#)
  - [In focus](#)
  - [Background](#)
  - [PHM Comment](#)

### Access to medicines and vaccines

#### In focus

As requested by Member States during the Seventy-first World Health Assembly (Decision [WHA71\(8\)](#)), the Secretariat has prepared a draft road map report outlining the programming of WHO's work on access to medicines, vaccines and health products ([EB144/17](#)). Lack of access to safe, effective, quality and affordable medicines and vaccines continues to impede progress towards universal health coverage. The draft road map elaborates activities, actions and deliverables for the period 2019–2023 to address the challenges and suggests milestones for implementation.

The Board will be invited to consider the draft road map and to provide further guidance. It is likely that the Secretariat be asked to continue to work on the road map before submitting it to WHA72, including perhaps providing budget estimates and targets and indicators.

#### Background

This item emerged at WHA70 in May 2017. There had been an existing agenda item dealing with shortages of medicines (from EB138 in Jan 2016) which had been proceeding (see [Tracker links to discussions of shortages](#)).

Then in September 2016 the UN Secretary General's High Level Panel on Access to Medicines reported ([announcement here](#)). The report provides a broad sweep of recommendations (see [Executive Summary](#)) relating to:

- TRIPS flexibilities and TRIPS-plus provisions;
- publicly funded research;
- new incentives for research;

- stronger accountability of governments;
- a stronger role for the UN SG and UNGA;
- greater disclosure and transparency by corporations;
- complete transparency regarding clinical trials;
- publicly accessible databases regarding patents and related data regarding medicines and vaccines.

However, the Officers of the Board chose not to include any reference to the HLP report in the agenda for EB140 but during consideration of the agenda ([PSR1](#)) it was agreed to discuss it under Item 8.5 ('Follow up of CEWG'). In this discussion (in the 11th meeting [here](#)) the USA (supported by Europe, Switzerland and Japan) was strongly opposed to any further consideration of the HLP report. Contrary views were presented by Colombia, India, Thailand, Algeria, Brazil, Iran and South Africa.

Including the HLP Report on the agenda for WHA70 (May 2017) was discussed in the 18th session of EB140 ([PSR18](#)) and it was agreed to add 'Access to medicines' to the foreshadowed item on 'Shortages of medicines and vaccines'.

WHA70 considered this item in May 2017. The item was initially deferred (see [PSR7](#)) to enable India and the US to sort out their differences. When the debate resumed ([PSR8](#)) India proposed that the subject be included on the agenda for EB142. Then followed a debate which was largely focused on shortages ([PSR8](#) and [PSR9](#)) and which ended by noting the Secretariat report ([A70/20](#)) and agreeing to review at EB142.

EB142 commenced its discussion (meeting 6, [here](#)) with a draft decision proposed by Algeria, Brazil, Chile, Colombia, Costa Rica, the Netherlands and Portugal which proposed recommending that WHA71 decide to ask the DG to prepare a roadmap "outlining the programming of WHO's work on access to medicines and vaccines, including activities, actions and deliverables for the period 2019–2023" to be submitted to WHA72 through EB144 in Jan 2019. This decision was adopted as [EB142\(3\)](#).

WHA71 considered and adopted this recommendation in May 2018 ([here](#)). The PHM analysis ([here](#)) prepared for WHA71 includes important background and commentary. Critical points include:

- the case for delinking is based on the neglect by the pharmaceutical industry of R&D for antibiotic development, for pandemic risks and for diseases which selectively affect poor people because of limited profit expectations;
- excellent policies adopted by the governing bodies are not being implemented because of the ongoing funding crisis facing WHO.

[EB144/17](#) reports on the process that the Secretariat has used to produce the draft roadmap which is presented in the Annex to [EB144/17](#). In A71/12, prepared for WHA71 in May 2018, the Secretariat listed all of the resolutions adopted by WHO governing bodies which together comprise the mandate for the Roadmap. This list is included as Appendix 1 to the Annex in EB144/17. The commitments so authorised are structured around two 'strategic areas' with eight 'activities' identified within those two strategic areas, and a series of 'actions' under

each of the eight 'activities'. 'Deliverables' are identified under each of the 'actions'. A set of milestones regarding the achievement of these deliverables is included in Appendix 2 to the Annex.

- Ensuring the quality, safety and efficacy of health products:
  - Regulatory system strengthening;
    - Development and implementation of WHO technical guidelines, norms and standards for quality assurance and safety of health products
    - Support improvement of regulatory systems, promoting reliance and collaboration
    - Strengthen preparedness for entry of medicines, vaccines and other health products into countries experiencing a public health emergency or crisis
  - Assessment of the quality, safety and efficacy/performance of health products through prequalification;
    - Maintain and expand the prequalification service
  - Market surveillance of quality, safety and performance;
    - Support strengthening national capacity to ensure the quality, safety and efficacy of health products
- Improving equitable access:
  - Research and development that meets public health needs and improves access to health products;
    - Continue to set priorities for health research and development in areas of compelling health need;
    - Coordinated actions on health research and development
    - Support improved capacity for research and development and clinical trials in countries
  - Application and management of intellectual property to contribute to innovation and promote public health;
    - Foster innovation and access to health products by appropriate intellectual property rules and management
    - Provide technical support and capacity building
  - Evidence-based selection and fair and affordable pricing;
    - Support processes for evidence-based selection, including health technology assessment and their implementation
    - Encourage more transparent and better policies and actions to ensure fairer pricing and reduction of out-of-pocket payments
  - Procurement and supply chain management; and
    - Support collaborative approaches to strategic procurement of health products
    - Support countries in efficient procurement and supply chain management of health products
    - Improve capability and capacity for detecting, preventing and responding to shortages of medicines and vaccines
    - Support for adequate supply management and appropriate use of health products in emergencies and crisis situations
  - Appropriate prescribing, dispensing and rational use.
    - Interventions that improve use of health products

- Support capacity for monitoring

See also the summary reports of regional committee discussions of this item from paras 11-15 of [EB144/3](#).

## PHM Comment

The draft roadmap is sensibly structured and brings together in a coherent way a wide range of programs and commitments which have previously been progressed separately. Secretariat staff are to be congratulated. However, there are some unfortunate omissions from the Roadmap which we list below. We also note that there are no budget estimates associated with the deliverables and timelines. PHM has repeatedly criticised the donor chokehold on WHO programming, The freeze on ACs and the tight earmarking of donor funds means that some deliverables may be funded but others will be completely unfunded.

### *Omissions for MS consideration*

Under **Regulatory systems strengthening** there are several references to quality standards and regulatory burden. What is not mentioned explicitly is the drive for the 'harmonisation' of standards through trade agreements associated with more and more demanding standards (as harmonised), beyond the requirements of safety, in order to exclude new market entrants, particularly those from low and middle income countries. This is a particular risk where private sector 'partners' from advanced manufacturing settings are involved in standard setting.

Under **Support improvement of regulatory systems, promoting reliance and collaboration**, there is no reference to investor state dispute settlement provisions in trade agreements and the possibility of these restricting the scope of regulation (there are six ISDS cases involving pharmaceutical companies listed in the [UNCTAD ISDS database](#)).

Under **Research and development for health products that meet public health needs** there is no explicit mention of the need for reliable information on the cost of pharmaceutical development including the relative roles of public funding and investor funding and the breakdown of funding across different stages/aspects of drug development.

Under **Foster innovation and access to health products by appropriate intellectual property rules and management** there is no reference to TRIPS Plus provisions in bilateral and plurilateral economic integration agreements. Such provisions impact negatively on access and affordability.

In relation to this action we also note the deliverable which refers to "**transparency regarding the patent status of existing and new health technologies**". This is a useful recommendation but MS must ensure that such transparency does not involve Patent Linkage provisions which are directed to harnessing the statutory powers of the NRA to police corporate IP claims. Breaches of IP are civil wrongs to be determined in civil jurisdiction. It is not the role of NRAs to police such claims.

Under **Encourage more transparent and better policies and actions to ensure fairer pricing and reduction of out-of-pocket payments** there is no mention of the role of publicly owned pharmaceutical manufacturing to promote competition and ensure greater

transparency in relation to costs of production (in fact the Roadmap appears to equate 'the private sector' with 'manufacturing', see for eg para 45).

Under **Interventions that improve use of health products** there is no reference to the regulation of the marketing of health products although [WHA60.16](#) (which urges MS to "to enact new, or enforce existing, legislation to ban inaccurate, misleading or unethical promotion of medicines, to monitor promotion of medicines") is listed in Appendix 1. We note that pharmaceutical companies defend their high profits in terms of the need to recoup expenditure on R&D. However, such companies spend much more on marketing than they do on R&D; marketing which often drives inappropriate use. If only a fraction of corporate marketing expenditure was redirected to supporting publicly accountable independent therapeutic advice platforms the rational and appropriate use of medicines would be greatly improved.

Likewise under this action there is no reference to provisions in economic integration agreements which require signatories to allow direct to consumer advertising notwithstanding the role of such marketing in driving inappropriate use.

### *Unspecified targets and limited indicators*

There is a very limited set of targets and indicators provided for (page 20), these being derived from the GPW13. The Roadmap will require more indicators to capture all of the deliverables and milestones included in the Roadmap.

### *Lack of specification of the different roles of different levels within the Secretariat*

The Roadmap provides no breakdown of what will be done in Geneva, the regional offices and the country offices nor how these different roles will be shaped.

### *Budget estimates*

The current draft of the Roadmap includes no estimates of the resources which will be needed to deliver the deliverables in accordance with the stated milestones. Perhaps the Secretariat wants to see the whole package endorsed in principle before providing budget estimates. However, it is hard not to be cynical regarding the likelihood of this package being adequately funded.

The freeze on ACs and the tight earmarking of donor funds means that some deliverables may be funded but others will be completely unfunded.

Powerful member states, led by the US, do not want WHO to be effective in promoting affordable reliable access to safe, effective and appropriately used medicines and vaccines if, in doing so, it undercuts the interests of the transnational pharmaceutical corporations.

The three countries which spoke against considering the recommendations of the HLP at EB140, the US, Switzerland and Japan, are the homes of some of the biggest pharmaceutical companies in the world. Not only are their governments harnessed to defend

the interests of *their* corporations but these are some of the very few countries which are net 'exporters' of intellectual property.

The 2006 Trade and health resolution ([WHA59.26](#)) provides a particularly egregious example of the determination of big pharma and its member state representatives to prevent WHO from implementing the mandates given by its governing bodies. See details in PHM's comment on this item at WHA71, [here](#).

**The draft roadmap will require further development in the lead up to WHA72. PHM urges MS to request the Secretariat to ensure that the above issues are properly addressed in the next iteration of the roadmap.**

## Cancer medicines

In focus at EB144

The high prices of and growing expenditure on cancer medicines continue to impede progress towards sustainable cancer care globally. Pursuant to resolution [WHA70.12](#) (2017), document [EB144/18](#) conveys the executive summary of a more extensive technical report on pricing approaches, and their impact on availability and affordability of medicines for the prevention and treatment of cancer, including options that might enhance the affordability and accessibility of the medicines concerned. (As of mid December 2018 the full report has not been published.)

### Background

[EB144/18](#) provides background to the development of this report which is further elaborated on the relevant [Secretariat webpage](#) including reference to the various expert groups who have participated.

The report describes different approaches to price-setting under two broad headings: industry approaches and payer (government and/or insurance companies) approaches. The report then summarises what is known regarding the impacts of different approaches to price setting on:

- price
- availability
- affordability
- R&D
- price transparency
- unintended negative consequences.

From this review the report identifies a range of options which might enhance affordability and accessibility (see Table). The options are grouped under:

- strengthening pricing policies
- improving efficiency
- improving transparency
- promoting cross-sector and cross-border collaboration
- managing demand-side factors

- realigning incentives for research and development.

#### PHM comment

This is a good report as far as it goes. There is very little here which does not apply with equal force to non-cancer medicines.

However, while the executive summary provides a smorgasbord of policy options it does not consider the broader governance capabilities (at the national and international levels) which would enable the implementation of the options listed, nor does it describe possible implementation models as they might operate at the national and international levels.

A critical set of governance capabilities arise in health care financing arrangements. Single payer health systems with publicly accountable payment arrangements are much more likely to have both the regulatory powers (eg through negotiation and procurement) and the coherence of purpose needed to implement many of the more promising options listed. In contrast health insurance organisations in competitive health insurance markets do not have the governance capabilities and face conflicting objectives in relation to the regulation of pharmaceutical pricing, procurement, marketing and utilisation.

The participation of private sector entities in various regulatory functions at the national and international level is a significant governance issue regarding the effective implementation of the options identified in this report. Examples include user pays arrangements for marketing approval and private sector involvement in the International Conference on Harmonization.

Another major issue of governance capability concerns the role of trade agreements (more accurately 'economic integration agreements') in constraining government regulatory capacity. Examples include TRIPS Plus provisions, ISDS provisions and higher than necessary harmonization requirements.

Hopefully the full report, when finalised, will provide more guidance on governance capabilities needed to implement various options and possible implementation structures.

The (executive summary of the) report does not refer to existing WHO programs and activities through which some of the options listed are already being progressed. MS need to be assured that such programs and activities are operating efficiently and are being adequately funded. Conversely the report does not identify the options, at the international level, which are currently not being progressed through WHO programs and activities.

**PHM urges MSs to request the DG to undertake further work on the affordability and accessibility of cancer medicines including more systematic consideration of necessary governance capabilities, implementation models and WHO programs.**

## 5.8 Follow-up to the high-level meetings of the United Nations General Assembly on health-related issues

### Contents

- [Antimicrobial resistance](#)
  - [In focus](#)
  - [Background](#)
  - [PHM Comment](#)
- [Prevention and control of NCDs](#)
  - [In focus](#)
  - [Background](#)
  - [PHM comment](#)
- [Ending TB](#)
  - [In focus](#)
  - [Background](#)
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### Antimicrobial resistance

#### In focus

Antimicrobial resistance is a growing global challenge that impacts the achievement of the Sustainable Development Goals. The Political Declaration of the high-level meeting of the United Nations General Assembly on antimicrobial resistance ([A/RES/71/3](#)) reaffirmed that the blueprint for tackling antimicrobial resistance is WHO's global action plan on antimicrobial resistance ([WHA68.7](#)), and recognized that the overarching framework for addressing antimicrobial resistance is provided by the One Health approach.

Document [EB144/19](#):

- reports on country level progress in developing and implementing national action plans on AMR;
- reports on progress at the global level in the implementation of the five Objectives of the Global Action Plan;
- summarises current trends in antimicrobial resistance in relation to tuberculosis, malaria, HIV, neglected tropical diseases and sexually transmitted infections;
- reports on interagency collaboration within the UN system;
- lists some ongoing challenges with regard to the development and implementation of national action plans; and
- highlights the specific threat posed by the carbapenem-resistant gram-negative bacteria, including carbapenem-resistant Enterobacteriaceae.

The Board is invited to note the report and provide further guidance; specifically the Board is asked to focus on:

- moving forward with the global development and stewardship framework (see 2018 [draft framework](#); see also the [ARC civil society consultation report](#) and [React commentary](#));

- accelerating Member States' implementation of national action plans for combating antimicrobial resistance (see [report of second round self-assessment survey](#), July 2018; see also [South Centre report on implementation of NAPs](#), Sept 2018);
- strengthening linkages at country level between plans for combating antimicrobial resistance and plans for universal health coverage, health security, and multisectoral action (refer [para 38 of EB144/19](#); see also references to 'platforms' in [the draft PB18-19](#)).

## Background

[Tracker links](#) to EB and WHA discussions of AMR since Jan 2014

The Political Declaration of the high-level meeting of the United Nations General Assembly on antimicrobial resistance ([A/RES/71/3](#))

The draft global development and stewardship framework (see 2017 [roadmap](#); 2018 [draft framework](#); see [Peter Beyer PPT](#), October 2018; see [Helle Aargaard reflections](#) on October 2018 consultation)

See also [WHO AMR website](#), including the [UN Interagency Coordination Group](#).

See also [React](#) website. See Dec 2018 React/DHF report on [Financing action on AMR](#).

See also [Antibiotic Resistance Coalition](#); lots of useful resources; see particularly [ARC Recommendations](#) (November 2018)

## PHM Comment

### *Global Framework for Development & Stewardship*

Responding to AMR is a sprawling challenge: it traverses different levels, sectors, issues, and disciplines. Much has been achieved over the last several years including the Global Plan of Action, the Political Declaration, the "Tripartite Plus", the IACG, the National Action Plans and a range of more specialised initiatives (surveillance, priority pathogens, 'access, watch, reserve' categorisation, pipeline assessment, etc).

Two major pillars remain to be put in place: governance and finance.

Governance (including regulation and accountability) encompasses:

- data collections: surveillance, monitoring health care and farming practices, etc;
- standard setting regarding sanitation, hygiene and infection prevention (including vaccination);
- regulation of healthcare practices, farming practices, pharma production practices;
- regulation and coordination of manufacturing, marketing, procurement, supply and utilisation;
- priority setting and coordination of research and development;
- national legislation and international instruments.

Finance encompasses:

- governing bodies, secretariats, administration;

- driving changes in practice, in particular, health care, farming, manufacture and research;
- financing R&D and financing access for both human and animal health.

The Global Framework for Development & Stewardship is designed to address both of these issues. Chapters 3, 4 & 5 (of the [October 2018 draft](#)) set forth the broad objectives, principles, targets and roles which would be provided for through the Framework in the areas of R&D, access and stewardship, and environmental aspects. Chapter 2 explores the legal forms the Global Framework could take. It considers the merits of conventions/treaties, regulations and strategies/codes/guidelines and suggests that different legal forms might co-exist within an ‘umbrella style’ global framework.

PHM urges MSs to recognise that there are many functions which will simply not be put in place unless there are binding requirements arising from conventions, treaties or regulations.

Annex 1 discusses possible financing mechanisms. The [Beyer PPT](#) provides a summary of the October 2018 draft covering functions, structures and financing

Helle Aargaard, policy advisor at ReAct, [reports](#) that there was some pushback at the October 2018 consultation from the US and the UK around WHO Guidelines on the use of antibiotics in animals which tell farmers to “Stop using antibiotics routinely to promote growth and prevent disease in healthy animals”. There may also be opposition to the provision for delinking in the draft Framework document (Annex 1, page 32).

PHM urges MSs to support the Guidelines. Expert opinion is unified on this principle.

PHM urges MSs to support the principle of delinking as a core principle of the AMR access funding package.

### *Financing*

There is a range of issues associated with financing: different functions, different levels, different national capacities. There is agreement that a range of different funding mechanisms will be required. Annex 1 of the October 2018 draft Framework indicates that quite large sums will be needed. Annex 1 reviews a range of possible financing mechanisms.

The [ReAct / DHF meeting in December 2018](#) identified six principles for AMR funding:

- Pay now or have to pay much more later.
- The form of funding mechanisms to follow the allocation of functions.
- Harnessing existing funds to become more AMR-oriented.
- Global financing channels to be visible and accessible to countries.
- A systems approach and the promotion of sustainability.
- Promote long-term sustainability.

PHM urges MSs to support the creation of a multilateral implementation fund (as described in Annex 1) as part of the Global Framework.

Patients and third party payers (government or insurers) are presently paying heavily for both R&D (and even more so for marketing) through purchase, procurement or reimbursement of drug expenditures. The funding of drug development under delinkage will

need to reroute these funds from purchase, procurement or reimbursement into a publicly accountable R&D fund.

### *Accelerating the implementation of national action plans*

Many countries did not respond to the second self-assessment survey ([here](#)). Many countries that did respond still do not have NAPs in place. Many of the countries which have NAPs do not have management structures in place or funding secured. Many of the countries which have NAPs in place have not yet implemented them (particularly in the animal sector). Many of the NAPs which have been implemented are weak in relation to key principles of the Global Action Plan.

It is a weakness of WHO that the provisions for holding MSs accountable for the implementation of WHA resolutions are generally weak.

In their report of the second self-assessment survey the 'Tripartite' flags the open access database of NAP self-assessments and suggests that civil society organisations (including both professional and community organisations) might access this database and advocate/mobilise around the need to develop robust NAPs and implement them.

PHM fully endorses this proposal, but as well as, not instead of holding MSs properly accountable for implementation.

PHM recognises the need for significant North South funding transfers and technology transfers to enable the development and implementation of national action plans. However, this does not void the need for accountability at the national level.

## **Prevention and control of noncommunicable diseases**

In focus

[EB144/20](#) reports on the commitments arising out of the [third high-level meeting of the UNGA](#) on NCDs (New York, 27 September 2018) and the follow-up work that the Secretariat proposes to undertake to support governments in fulfilling the commitments they made at the [first](#) (2012), [second](#) (2014) and third High-level Meetings on Non-communicable Diseases.

The Secretariat's plan for follow up work includes:

- a 'delivery plan' regarding technical assistance to MSs;
- identifying a subset of 'NCD accelerators' from among the best buys in the revised [Appendix 3 of the GAP](#);
- three flagship programs on mental health, heart health, and cervical cancer (see para 9);
- a note on scientific knowledge base for effective taxation on sugar-sweetened beverages ([Annex 2](#));
- further work on registering and publishing the contributions of NSAs including private sector entities to prevention and control of NCDs ([Annex 3](#) and also [EB144/20 Add.1](#), below);
- meetings with national NCD directors and program managers;

- six monthly [dialogues](#) between WHO and private sector stakeholders (food and beverage, pharmaceuticals, alcohol, sports); see 2018 dialogues with [alcohol](#); meetings with [food and beverage](#) and with [pharma](#);
- further work by the [Independent High-level Commission on NCDs](#); see June 2018 [Report](#);
- 'strategic opportunities to leverage political championing' (para 15);
- data collection for reporting to UNGA in 2024 (see [Annex 4](#));
- global conference on air pollution (Nov 2018);
- new partnerships, to be developed through the [Inter-agency Taskforce](#), with governments, NGOs, private sector entities, academic institutions and philanthropic foundations.

In addition the Secretariat will progress the midpoint evaluation of the [Global Action Plan](#), 2013-2020 in early 2019 to report to WHA72 in May 2019 (delayed because of lack of money).

The Board is invited to note the report.

[EB144/20 Add.1](#) sets out the proposed workplan for the remainder of the term of the [Global Coordination Mechanism on NCDs](#) (GCM/NCD) for 2020. The proposed work plan includes three strategic priorities and a number of actions under each:

- foster multistakeholder collaboration:
  - conduct a stocktake of engagements of governments with non-state actors, including through PPPs;
  - develop an approach to register and publish the contributions of NSAs to NCDs (see [Annex 3](#) of EB144/20);
  - promote 'meaningful civil society engagement' (through [WHO's Civil Society Working Group](#)) to encourage governments to adopt multisectoral approaches;
- promote better understanding of challenges at national level:
  - a policy brief on how to raise the priority assigned to NCD prevention and control;
  - a policy brief on how to address economic, market and commercial factors;
  - promote investment in implementation research in L&MICs;
- pilot capacity building approaches at national level:
  - develop and pilot a technical package to support governments to establish multistakeholder and multisectoral mechanisms;
  - document, stocktake and disseminate advocacy campaigns and communication packages to educate the public regarding risk factors.

The Board is invited to note the report.

## Background

See [Tracker links](#) to EB and WHA discussions of NCDs since 2010. See in particular PHM's comment on WHA70, [Item 15.1](#) which reviews the pre-history of WHO's sprawling engagement with NCDs.

## PHM Comment

In aggregate little progress is being made globally (see [WHA71/14](#)). However, in distributional terms, the gap is widening between high income countries and low and middle income countries and within countries between rich and poor classes.

### *The multistakeholder dialogue*

The most striking thing emerging from the two documents prepared for this item is the explosion of enthusiasm for multistakeholder dialogue or more precisely WHO engaging with powerful private sector entities with entrenched commercial interests in NOT implementing the Appendix 3 'best buys':

- the Secretariat is planning on six monthly dialogues with the food and beverage industry, the pharmaceuticals industry, the alcohol industry and sporting bodies;
- the Inter-agency Taskforce is planning on developing 'new partnerships' including with private sector entities;
- WHO's GCM/NCDs is planning on conducting a stocktake of governments' engagements with non-state actors (including private sector entities) and piloting a 'technical package' on establishing multistakeholder mechanisms.

These dangerous liaisons come on top of the completely bizarre requirement from 2014 for an approach to register and publish the 'contributions' of NSAs (including private sector entities) to the prevention and control of NCDs (see [Annex 3](#) of EB144/20).

In this context it is useful to go back to [WHA71/14](#) which includes at Table 5, a useful overview of the barriers at national and subnational levels to the implementation of the [Appendix 3](#) best buys and, in Table 6, of the lessons learned regarding the implementation of best buys. The report notes that:

- *"Interference by industry impedes a number of governments in implementing some of the best buys and other recommended interventions for the prevention and control of noncommunicable diseases, including raising taxation on tobacco products, alcoholic beverages and sugar-sweetened beverages, and enacting and enforcing bans or restrictions on exposure to tobacco and alcohol advertising, promotion and sponsorship;"*
- *"Multinationals with vested interests regularly interfere with health policy-making, for instance by lobbying against implementation of the best buys and other recommended interventions, working to discredit current scientific knowledge, available evidence and reviews of international experience, and bringing legal challenges to oppose progress. In some instances, these efforts are actively supported by other countries, for instance through international trade disputes."*
- *"In developing tobacco plain packaging laws, some governments overcame substantial tobacco industry opposition, including in the form of lobbying, public campaigning, attempts to discredit current scientific knowledge, available evidence and reviews of international experience, and litigation in multiple forums. The success of countries moving forward can be attributed to factors including sustained political support, a whole-of-government and evidence-based approach, commitment of sufficient resources, stakeholder consultation on policy implementation and strong technical capacity".*

The multistakeholder partnership has been a demand of the NCD corporations for a long time. “We just want a seat at the table.” However, there are significant risks associated with this dialogue-with-the-corporates approach:

- corporate capture: favours are done, friendships develop, opportunities emerge;
- giving away more than you get; the value of gossip; a hint here suggests the need to lobby there;
- influence: maybe not such a problem in Geneva but clearly an issue in small L&MICs when well resourced advocates for big business confront low paid and very stretched officials.

It is hard not to speculate that Dr Tedros has made a deal with powerful donors; he might get his 8% increase in donor funds if he shows that WHO can be more friendly with the corporates.

The [USA](#) and [Italy](#) were critical of the redrafted Appendix 3. “They stated, inter alia, that they believe that the evidence underlying certain interventions was not yet sufficient to justify their inclusion. They considered that the proposed interventions should also reflect the view that all foods could be part of an overall healthy diet.” These objections are identical to those of the food and beverage industry.

But WHO is supposed to be an evidence / science based body. There has been no evidence cited that cosying up to the corporates drives effective change; there has been no evidence cited that *it does not favour the corporates*; if this is not the case, why are they so keen?

### ***Technical support***

Fragile and poorly resourced health systems have limited capacity to drive and support prevention and control. Addressing such weaknesses require whole-of-health system strengthening. Technical support focused on NCDs will have limited effectiveness.

The policy capacity needed to drive the best buys implementation through health system programs, intersectoral collaboration, regulation and fiscal strategies is significant. Most L&MICs have limited policy capacity; this is a whole of government issue, not something that can be resolved through vertical, NCD-focused technical support.

Nevertheless, there is clearly a demand for technical support from WHO and undoubtedly such support can make some difference, no matter the existing level of national capacity. However, WHO’s NCD programs and the Inter-agency Taskforce programs are underfunded or completely unfunded. While there is a risk of countries actually addressing the commercial determinants of NCDs, WHO’s donors remain reluctant to support real action on NCDs.

### ***Civil society engagement and comprehensive PHC***

PHM notes the commitment to ‘meaningful civil society engagement’. However, we note also that many of the members of the WHO Civil Society Working Group are associated with organisations which have ongoing relations with private sector entities. It is not clear how the risk of conflicts of interest is being managed.

Promoting civil society engagement needs to reach from the global to the local and to extend beyond semi-professional organisations to local level community networks. It is a core principle of comprehensive primary health care that local PHC agencies and practitioners are working in partnership with their communities to raise awareness, take action locally and advocate for policy change. Strengthening comprehensive PHC should be given greater priority in the NCD strategy.

## **Ending tuberculosis**

### **In focus**

The first United Nations High-level Meeting on the Fight to End TB was held in New York on 26 September 2018. [EB144/21](#) provides an overview of the meeting and its outcomes.

### **Background**

[Tracker links](#) to recent discussions of TB in EB and WHA.

### **PHM Comment**

TB remains a major public health concern.

The initiatives highlighted in the report are important and well directed.

PHM particularly appreciates the recognition that ending TB must involve health systems strengthening: coordinated health systems that simultaneously involve multiple programmes, stakeholders, and initiatives in a continuum of concerns, from health services to socioeconomic factors.

We reaffirm the importance of realising the principles of comprehensive Primary Health Care including with inter-sectoral and participatory processes.

PHM urges WHO to continue to explore innovative mechanisms for the funding of research and development of diagnostic and therapeutic products that delink research and development funding from patent-based monopoly pricing.

PHM urges WHO to ensure that the social context of TB infection is fully documented and reported on as part of generating political pressure for structural change to address the social and political context within which vulnerable groups (migrants, indigenous peoples, and refugees, among others) are exposed to TB and are able to access preventive protections and appropriate treatments.

PHM urges WHO to work more closely with the UN Human Rights Council to explore ways of using human rights instruments to ensure the right to health, including the right to diagnosis, treatment, and care; and to hold health systems and governments accountable for access and treatment.

## 5.9 Eleventh revision of the International Classification of Diseases

### Contents

- [In focus](#)
- [Background](#)
- [PHM Comment](#)

### In focus

The report by the Director-General ([EB144/22](#)) will provide an update on the feedback received on the implementation version of the eleventh revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-11), and a summary of the overall process. The Board will be invited to consider a draft resolution.

### Background

[EB144/22](#)

### PHM Comment

Bringing ICD11 to this stage has been a huge undertaking. The updated classification and the upgraded functionalities will add significantly to the quality of data available for planning, accountability and research.

PHM extends the warmest congratulations and thanks to the Secretariat and all of those who have been involved and urges MSs to adopt the proposed resolution.

## 6.1 Pandemic Influenza Preparedness Framework for the sharing of influenza viruses and access to vaccines and other benefits

### Contents

- [In focus](#)
- [Background](#)
- [PHM Comment](#)
- [Notes of discussion](#)

### In focus

Pursuant to decision [WHA70\(10\)](#) (2017), document [A71/24](#) (2018) and decision [WHA71\(11\)](#) (2018), the Director-General will submit a report on measures taken to implement the requests contained therein ([EB144/23](#)).

The various issues reported on in EB144/23 have long and braided genealogies which are not clearly presented in this report. These genealogies need to be traced back, at least, to the 2016 PIP Review Group report.

#### Implementing the recommendations of the 2016 PIP Review Group

The report of the 2016 PIP Review Group was conveyed to the Assembly in [A70/17](#).

In Decision [WHA70\(10\), para 8\(a\)](#) the DG was requested to take forward the recommendations of the Review Group.

In para 5 of [A71/24](#) the Secretariat reported to WHA71 on progress on this request and in para 19(a) committed to completing the implementation of the recommendations of the 2016 PIP Review Group before WHA72. This recommendation was endorsed in [Decision 71\(11\)](#).

In [EB144/23](#), para 2, the Secretariat reports that this has been completed

#### Strengthening critical pandemic preparedness (and the Partnership Contribution Implementation Plan 2018–2023)

In [Section 6.3](#) the PIP Review Group commented on the Partnership Contribution implementation (see [findings 48- 55 of the PIP RG report](#)).

In Decision [WHA70\(10\)](#), para 8(c) the DG was requested to “continue supporting the strengthening of regulatory capacities and carrying out burden-of-disease studies, which are fundamental foundations for pandemic preparedness” .

In paras 10-11 of [A71/24](#) the Secretariat responded to this request highlighting the importance of the [Partnership Contribution Implementation Plan 2018–2023](#) and in para 19(c)(i) undertook to continue the implementation of the Plan to this end. This undertaking

was endorsed in Decision [WHA71\(11\)](#). In [EB144/23](#), para3, the Secretariat reports on the implementation of the Partnership Contribution Implementation Plan 2018–2023.

## Concluding Standard Material Transfer Agreements 2 and the collection of annual PIP Partnership Contributions

Key findings regarding SMTA2s are summarised in [findings 34-42](#) of the Review Group report (in A70/17) leading to recommendations [18-22](#). Findings [43-45](#) deal with the collection of the PC leading to recommendations [23-24](#).

In Decision WHA70(10), para 5, the Assembly recognised the progress being made and in para 8(d) the DG was requested “to continue encouraging manufacturers and other relevant stakeholders to engage in PIP Framework efforts, including, where applicable, by entering into Standard Material Transfer Agreements 2 and making timely annual PIP Partnership Contributions”. The Secretariat reported in [A71/24 para 13](#), on progress regarding this request. In A71/24, para 19(c)(ii), the Secretariat undertook to conclude more SMTA2s. This was endorsed in WHA71(11), Annex (c)(ii). In EB144/23, para 4, the DG refers to the reporting of PIP PCs in the [June 30, 2018 Progress Report](#) and through the [Programme Budget portal](#).

## Engagement with the secretariats of the Convention on Biological Diversity and other relevant international organizations

Findings [70-73](#) and recommendation [36](#) of the Review Group concern the relationship of the PIP Framework to the Nagoya Protocol of the CBD.

In [WHA70\(10\)](#), para (6) the Assembly decided to “recognize the ongoing consultations and collaboration between WHO and the Secretariat of the Convention on Biological Diversity and other relevant international organizations” and in para 8(f) requested the DG to “continue consultations with the Secretariat of the Convention on Biological Diversity and other relevant international organizations, as appropriate”.

In paras 17-18 of [A71/24](#) the Secretariat advised the Assembly of progress in response to this request and in para 19(c)(iii) undertook to continue such engagement. This was endorsed by the Assembly in [WHA71\(11\)](#), Annex (c)(iii).

In para 5 of [EB144/23](#) the Secretariat reports that such engagement is ongoing (see [report of June 2018 Consultation](#)).

## Implementing the recommendations of the External Auditor

The Review Group reported concerns and misunderstandings regarding the collection and use of partnership contributions (PCs), see [pp 18-19 of A70/17](#). In para 8(e) of [WHA70\(10\)](#) the Assembly asked the Secretariat to organise an audit of the PCs.

In [para 15 of A71/24](#) the Secretariat reported on the outcomes of this audit and in [WHA71\(11\), Annex \(d\)](#) the Assembly endorsed the undertaking of the Secretariat to implement the auditor’s recommendations.

[EB144/23](#), para 6, reports that the recommendations of the Auditor have been implemented.

## The sharing of seasonal influenza viruses and genetic sequence data

In [Finding 11](#), the Review Group reported receiving wide-ranging views from key informants, including Member States, industry and civil society, on including seasonal influenza under the PIP Framework, with strong views both for and against, and judged that the implications of including seasonal influenza need to be studied further. Rec 3 was that “the Director-General should undertake a study to determine the implications and desirability of including seasonal influenza viruses in the PIP Framework”. More detailed discussion in [Section 3.2.1](#) from page 34.

The Review Group’s summary of its [findings and recommendations \(12-17\)](#) regarding the sharing of GSD are quite specific.

In [WHA70\(10\)](#), para 8(b) the Assembly decided to request the DG:

*regarding the PIP Framework Review Group’s recommendations concerning seasonal influenza and genetic sequence data, to conduct a thorough and deliberative analysis of the issues raised, including the implications of pursuing or not pursuing possible approaches, relying on the 2016 PIP Framework Review and the expertise of the PIP Advisory Group, and transparent consultation of Member States and relevant stakeholders, including the Global Influenza Surveillance and Response System;*

In [A71/24](#), para 19(b), the Secretariat advised the Assembly that “The Secretariat intends to complete the analysis in order to submit a comprehensive draft to the Seventy-second World Health Assembly through the Executive Board at its 144th session”. This was endorsed in [WHA71\(11\)](#) and in [EB144/23](#) (paras 7-24) the development of the draft analysis is described; the outcomes of the October 2018 consultation are summarised and the [finalised analysis](#) is referenced.

The issues associated with the possible inclusion of seasonal influenza under the PIP Framework were discussed by the PIP Framework Advisory Group from October 17-19, 2018. The Advisory Group’s considerations and recommendations are contained in [paras 43-52](#) of the report of the October meeting.

The Advisory Group’s considerations regarding the treatment of genetic sequence data under the PIP Framework and related recommendations are contained in [paras 53-65](#) of the report of the October meeting.

## Draft decision

The draft decision at para 25 of [EB144/23](#) includes a broad request to continue to work on uncertainties arising between the PIP Framework and the Nagoya Protocol and some specific initiatives (the search engine, the principle of acknowledgement, and the amended footnote).

## Background

The pandemic influenza preparedness framework ([here](#)) was developed because of concern regarding inequities that had emerged in the context of WHO influenza sharing through what was then known as the Global Influenza Surveillance Network (GISN). Countries shared influenza viruses with WHO linked laboratories, which in turn shared candidate vaccine viruses with vaccine manufacturers, but no benefits were returned to WHO or the countries that shared the influenza viruses. In fact countries that shared the influenza viruses often were not able to gain access to the vaccines, either because they were unavailable or because they were unaffordable. Discussions over the inequities peaked in 2007, leading to intensive negotiations and finally a [Framework](#) for virus and benefit sharing in 2011.

Under this Framework recipients of viruses have to share benefits. Benefits are shared through two channels: SMTA agreements and partnership contributions.

Recipients of biological materials are required to enter into an agreement with the WHO known as the Standard Material Transfer Agreements (SMTA) to indicate how the benefits of accessing these materials are to be shared with the WHO. Two different SMTAs are provided for. SMTA1 is for entities within the GISRS receiving materials. SMTA2 is for entities outside the GISRS receiving materials. The benefits shared under SMTAs are largely in-kind benefits. (See details of SMTAs in Annex 1 & 2 of the [PIP Framework](#).)

Entities outside the GISRS are also expected to make 'partnership contributions' to WHO to help support the Global Influenza Surveillance and Response System (GISRS). See [Financial Report at Annex 1](#) of 2016 PIP Framework Partnership Contribution 2013-16 Annual Report. The distribution of the partnership contribution obligation is determined in accordance with rules (8 May, 2013) [here](#). The use of the partnership contribution is governed by Decision [EB131\(2\)](#) from May 2012: broadly 70% is to be used for preparedness (laboratory and surveillance) and 30% reserved for to support response capability. See [PC webpage](#) for more.

An Advisory Group was set up to monitor implementation of the PIP framework. This Group meets twice a year.

The implementation of the Nagoya Protocol under the Convention on Biological Diversity (see [EB140/15](#)) has complicated the operations of the PIP Framework:

- national implementation legislation appears in some cases to have created obstacles to the sharing of biological materials as provided for under the PIP Framework;
- consideration of access and benefit sharing in relation to seasonal influenza and other pathogens and in relation to genetic sequence data are complicated by inconsistencies between the PIP Framework and the Nagoya Protocol;

More about PIP on WHO website [here](#).

See [Tracker links](#) to previous discussions by WHA and the EB of the PIP Framework.

## **PHM Comment**

The principles of access and equitable benefit sharing are simple but the implementation issues are extremely complex. The draft decision provides for continued exploration and incremental change.

## 6.2 Member State mechanism on substandard and falsified medical products

### Contents

- [In focus](#)
- [Background](#)
- [PHM Comment](#)

### In focus

The sixth and seventh meetings of the Member State mechanism on substandard and falsified medical products were held in Geneva, Switzerland from 30 November to 1 December 2017, and on 29 and 30 November 2018 respectively. Updates on the implementation of the agreed list of prioritized activities for the period 2016–2017 were discussed, and a new list of prioritized activities for the period 2018–2019 was agreed. The outcome documents from both meetings form the basis for reporting to the Executive Board (in [EB144/24](#)).

The reports of the sixth and seventh meetings need to be read with the [Appendix to the sixth meeting](#) open so that the references to ‘activities’ are given further context.

These two reports are on the EB agenda because of a previous commitment to report to the Assembly every two years. The debate is likely to be short.

### Background

The Secretariat’s Substandard and Falsified (SF) Medical Products page is [here](#). This links to a range of publications and activities undertaken through the Secretariat including regulatory strengthening and capacity building.

The index page to the meetings of the member state mechanism (MSM) on substandard and falsified medical products is [here](#). From here are linked the agendas, papers and reports from all of the 7 MSM meetings.

See [Tracker links](#) for previous governing body discussions of SF medical products. See in particular the [Background note to PHM comment](#) on Item 8.6 at EB140 which explains the origins of the MSM and sets out the timelines regarding this issue.

See also [Item 13.6 at WHA70 \(2017\)](#) at which time the terminology issue was resolved with SSFFCMP replaced by Substandard and Falsified and ‘counterfeit’ was finally dropped.

### PHM Comment

It seems that since the nomenclature issue was resolved there is not much happening under the MSM umbrella that could not be resumed into the normal processes of the EB and WHA.

However, the fundamental tensions over medicines regulation and its relationship to intellectual property claims remain at large.

## 6.3 Human resources for health

### Contents

- [In focus](#)
- [Background](#)
- [PHM Comment](#)

### In focus

Pursuant to resolution [WHA63.16](#) (2010) and decision [WHA68\(11\)](#) (2015) document [EB144/25](#) reports on the aggregate findings across WHO regions from the third round of national reporting on implementation of the [WHO Global Code of Practice](#) on the International Recruitment of Health Personnel.

Report [EB144/26](#) summarizes progress made in the implementation of the WHO Global Strategy on Human Resources for Health: Workforce 2030, in line with the request made by the Health Assembly in resolution [WHA69.19](#) (2016). The report also provides details of progress made in respect of the following resolutions: [WHA64.6](#) (2011) on health workforce strengthening; [WHA64.7](#) (2011) on strengthening nursing and midwifery; and [WHA70.6](#) (2017) on human resources for health and implementation of the outcomes of the United Nations' High-Level Commission on Health Employment and Economic Growth.

### Background

[Tracker links](#) to previous EB/WHA discussions of human resources for health.

### PHM Comment

Lack of trained health workers with appropriate supports is a fundamental obstacle to accessing decent health care for many millions of people.

The impact of inter-governmental organisations, conferences, agreements and statements is limited:

- Better data is good; clearly the situation is complex.
- Technical assistance (data, policy, bilateral agreements) is useful at the margins.
- Rhetoric about ethical recruitment may have a marginal effect.
- Raising awareness about countries which have critical workforce shortages may have a marginal effect.

However, health system strengthening at the local and national levels, including appropriate training and decent secure jobs, is fundamental. This depends on governance capacity and resources both of which are held hostage to the pressures and imbalances of neoliberal globalization.

This may be why many countries, particularly in the Africa region have not designated national authorities and many countries, including several high income recipient countries, had not submitted reports by 4 October.



## 6.4 Promoting the health of refugees and migrants

### Contents

- [In focus](#)
- [Background](#)
- [PHM Comment](#)

### In focus

Pursuant to decision [EB140\(9\)](#) (2017) and resolution [WHA70.15](#) (2017), the report [EB144/27](#) provides an update on the status of the proposed global action plan on the health of refugees and migrants.

### Background

See [Tracker links](#) to recent governing body discussions of migrant and refugee health. See in particular [A70/24](#) which sets out a framework of priorities and guiding principles.

See also the summary reports of regional committee discussions of this item from paras 16-19 of [EB144/3](#).

See the 2016 [New York Declaration for Refugees and Migrants](#) and the 2018 report of UN Secretary General on International migration and development ([A/73/286](#)).

See [UN index page](#) for the Global Compact on Migration (commissioned Sept 2016; finalised July 2018; adopted December 2018).

### PHM Comment

There has been a huge increase in migration and asylum seeking over the last two decades. There are many causes for this including intolerable conflict and deprivation as well as pro-migration policies and individual aspiration. Likewise there are many consequences including disease, injury, suffering and death as well as benefits for individuals, families and societies.

PHM commends the resolution of [WHA70.15](#) calling for the Secretariat to develop a global action plan on the health of refugees and migrants.

We note that action on the health of migrants, asylum seekers and refugees should be aligned with wider action such as that called for in the 2016 [New York Declaration for Refugees and Migrants](#) and the [Global Compact for Safe, Orderly and Regular Migration](#) (July 2018).

We note that the draft global action plan presented in [EB144/27](#) is structured around six priorities, each of which comprises a general objective and a set of options for Secretariat action.

There is nothing in this draft which commits member states to any action or which might hold member states accountable with respect to previous commitments or established international norms. This is quite unusual. There was nothing in resolution [WHA70.15](#) which required the draft to be limited to Secretariat action only and, given the broad commitments which most member states have agreed to through the New York Declaration and the Global Compact, the concept of including member state commitments and accountabilities should not have been ignored thus.

The content of the plan is even more limited. Priority Action 4 takes an extremely restricted view of the concept of social determinants of health: “*Ensure that the social determinants affecting refugees’ and migrants’ health are addressed through joint action and coherent multisectoral public health policy responses*”. This appears to exclude the social determinants which drive asylum seeking and which lie behind the present health challenges of refugees and migrants. This is analogous to emergency department doctors who provide excellent care for brutalised women but do not inquire about the source of the violence.

This exclusion is even more regrettable in view of Objective 2 of the [Global Compact](#) which commits signatories to minimising “*the adverse drivers and structural factors that compel people to leave their country of origin. We commit to create conducive political, economic, social and environmental conditions for people to lead peaceful, productive and sustainable lives in their own country and to fulfil their personal aspirations, while ensuring that desperation and deteriorating environments do not compel them to seek a livelihood elsewhere through irregular migration.*”

If the social determinants of health means anything it requires that the health authorities document the role of such ‘adverse drivers and structural factors’ in harming people’s health.

It is bizarre to recognise the dramatic increase in the number of migrants and asylum seekers over the last two decades and ignore:

- the roots of war and communal violence which contribute to driving migration and asylum seeking;
- the roots of economic stagnation and widening inequality which through poverty and contribute to driving migration;
- the vicious cycle through which economic hardship plus the political use of xenophobia promotes violence which drives migration and asylum seeking;
- global imperialism under which big powers can invade smaller countries with impunity;
- neoliberal globalisation always teetering on the brink of collapse but stabilising itself through further immiseration of the ‘reserve armies of the poor’; maintained to keep labour costs low and transfer production to if labour costs rise; and
- a trade regime which promotes free movement of all of the inputs to production except labour.

The importance of including provisions in the global plan which would strengthen member state accountability in relation to the drivers as well as the management of migration and asylum seeking is well illustrated by the several countries which have refused to adopt the (non-binding) Global Compact, perhaps because its condemnation of xenophobia and extended immigration detention.

Several of the countries refusing to adopt the Global Compact may have reason to object to Objective 17, under which signatories “commit to eliminate all forms of discrimination, condemn and counter expressions, acts and manifestations of racism, racial discrimination, violence, xenophobia and related intolerance against all migrants”.

Australia which is notorious for its use of immigration detention for deterrence is one of those countries which has refused to adopt the Compact, perhaps because of Objective 13 “Use immigration detention only as a measure of last resort and work towards alternatives” and para 29(c):

*Review and revise relevant legislation, policies and practices related to immigration detention to ensure that migrants are not detained arbitrarily, that decisions to detain are based on law, are proportionate, have a legitimate purpose, and are taken on an individual basis, in full compliance with due process and procedural safeguards, and that immigration detention is not promoted as a deterrent or used as a form of cruel, inhumane or degrading treatment to migrants, in accordance with international human rights law*

## 6.5 Accelerating cervical cancer elimination

### Contents

- [In focus](#)
- [Background](#)
- [PHM Comment](#)

### In focus

Vaccination against human papillomavirus infection, screening and treatment of pre-cancerous lesions, early detection and prompt treatment of early invasive cancers, and palliative care are proven and cost-effective strategies to address cervical cancer that, when implemented to scale and with adequate coverage, offer the opportunity to eliminate cervical cancer as a public health problem, thus contributing to achievement of the Sustainable Development Goals, universal health coverage and other public health goals requiring multisectoral action. The Board is invited to note the report ([EB144/28](#)) and provide further guidance.

### Background

[Tracker links](#) to recent governing body discussions of cancer.

### PHM Comment

This is a useful document. The epidemiology and cost effectiveness data confirm the package on offer has the potential to make a huge impact on women's health globally, particularly in lower income strata and L&MICs.

The three accelerators which are identified (para 11) are critical to the package:

- Accelerator 1. A concerted multistakeholder effort is needed between governments and non-State actors, particularly the private sector, to overcome current human papillomavirus vaccine supply constraints and negotiate more affordable prices through market shaping;
- Accelerator 2. A concerted multistakeholder effort to establish a sufficient, affordable supply of human papillomavirus screening tests and treatment technologies for cervical pre-cancer is required to accelerate the impact of screening programmes in terms of test effectiveness and simpler delivery;
- Accelerator 3. Technical assistance and support to Member States is required to scale up their capacity for coordinated and integrated delivery of diagnosis, cancer surgery and radiotherapy, systemic therapy and palliative care services.

However, the accelerators are cast at a very high level of generality, particularly the first two. More work will be needed to establish exactly what the vaccine supply constraints are and how they might be overcome and to establish how best to approach the challenge of affordable prices.

The reference to ‘market shaping’ and ‘negotiating’ suggests the Secretariat is promoting a mechanism such as advance purchase commitments. Member states are urged to keep the delinking option on the table. The cost of vaccination is going to come out of the public purse one way or the other; upstream funding of the R&D costs will enable the vaccine to be distributed at cost for equitable access.

The second accelerator envisages a ‘concerted multistakeholder effort’ to establish a sufficient and affordable supply of tests and treatment technologies. This appears to imply, at least for LICs, a new dedicated vertical funding program. The Secretariat needs to be asked to explore closely the barriers to a sufficient and affordable supply and to provide a full range of options for the MSs to consider.

Fundamentally the elimination of cervical cancer will depend on whole-of-health-system-strengthening. The “*coordinated and integrated delivery of diagnosis, cancer surgery and radiotherapy, systemic therapy and palliative care services*” is not something that can be achieved on a one disease basis. Insofar as the barriers to ‘coordinated and integrated delivery’ are lack of specific technical knowhow WHO country and regional offices will be able to contribute but the main barriers are likely to be more general health system governance and resources issues. Member states are urged to request further exploration of the barriers to ‘coordinated and integrated delivery’.

PHM looks forward to the next iteration of this proposal.

## 6.6 Patient safety

### Contents

- [In focus](#)
- [Background](#)
- [PHM Comment](#)

### In focus

#### Global action on patient safety

Patient safety is a critical global public health objective. An inadmissible number of patients are harmed or die each year as a result of unsafe care, placing a significant burden on health systems across the world and jeopardizing progress towards universal health coverage. At the request of Member States, the Director-General will provide a report outlining the burden of patient harm, global efforts made to date in support of patient safety and key global action areas and strategies for taking this work forward ([EB144/29](#)). The Executive Board will be invited to note the report and provide further guidance to advance global action on patient safety.

#### Water, sanitation and hygiene in health care facilities

The first-ever global assessment on this matter, conducted in 2015 by WHO and UNICEF, found that nearly 40% of facilities lack water, 20% are without sanitation, and 35% do not have any hand hygiene materials. This situation undermines universal health coverage, quality care initiatives, and infection prevention and control efforts. It also contributes to the spread of antimicrobial resistance. In response, launching the International Decade for Action “Water for Sustainable Development” 2018–2028, the United Nations Secretary-General issued “a global call to action on water, sanitation and hygiene” in all health care facilities in March 2018. In light of this background, and at the request of a Member State, the Director-General will submit a report on the subject ([EB144/30](#)). The Board will be invited to note this report and provide guidance on future action.

### Background

See WHO website index pages to [Patient Safety](#) and [Water, Sanitation Hygiene](#).

### PHM Comment

#### Patient safety

The data are worrying; both the morbidity and the costs. Undoubtedly the kinds of errors and harms listed in para 4 are common in all health care systems. Patient safety is a major issue globally.

However, this document is quite unsatisfactory in a number of ways.

There is very little here about causation and nothing about one of the most salient causes in L&MICs which is lack of resources (supplies, staff, electricity, maintenance, etc).

The document affirms that patient safety needs to be addressed as a system issue in the context of local realities. However, the analysis of barriers to progress (in para 13) is largely structured in relation to the specificities of patient safety rather than the broader challenges of health system strengthening. The discussion of strategies for improving patient safety does not address health care financing arrangements and the anarchy of privatised medical and hospital services in many countries.

There is quite a lot on EB144/29 about what the WHO Secretariat has been doing but, notwithstanding the acknowledgement that not much has changed in the last 15 years, there does not seem to have been any independent review provided to the governing bodies regarding the strategic directions of the Secretariat's work in this domain.

The Secretariat's work in patient safety includes awareness raising, production of technical resources and networking and in paras 24-25 the document promises more of the same.

Some of the questions which a review of this programme might ask:

- Why has patient safety been so sharply separated from questions of quality of care? These are not the same but closely overlap in causation and strategy.
- Why is there no discussion of various approaches to 'clinical governance' as a system wide approach to measurement and accountability? How can the principle of clinical governance be realised under different health care financing arrangements, in particular in chaotic privatised systems. How can health care financing arrangements be leveraged to promote quality and safety in low resource settings?
- Why is patient safety being so sharply compartmentalised away from broader questions of health systems strengthening? One of the core principles of patient safety is 'institutional resilience'; recognising that humans make mistakes but safe (resilient) institutions prevent those mistakes from causing harm. Resilience in low resource settings is a particular challenge which deserves more attention. Clinical governance, institutional resilience, a culture of caring, respect for professionalism and building trust are all challenges of health system strengthening generally.
- To what extent is the isolationism of the patient safety program a function of its funding. Who funds WHO's patient safety work and are those funds tightly earmarked and if so do donor preferences influence the orientation and approach adopted by the Secretariat?

PHM has long worried that the slogan of UHC was introduced to avoid seriously engaging with the challenges of health system strengthening because of the sensitivity of organisational structures and health care financing. Addressing patient safety separately from quality of care and health system strengthening may reflect the same caution.

PHM urges MSs to request an independent review of the Secretariat's work in patient safety within the context of the broader challenges of health system design, health care financing and health system strengthening.

## WASH in health care facilities

The prevalence of health care facilities without water, adequate sanitation, capacity for hand hygiene, or safe management of waste is dreadful. The consequent morbidity (and loss of trust) is huge. As EB144/30 comments (para 1), “*These failings undermine the promise of universal health coverage.*”

The barriers to full provision of WASH capabilities and practices in health care facilities are significant: overburdened staff, low expectations, bureaucratic backwaters, budget neglect and lack of data.

Experience shows that incremental change is possible and builds enthusiasm for further change. Political and managerial leadership are critical.

WHO is promoting improved data collections, technical support at the country level, encouragement of intersectoral collaboration at the country level and the practice of such collaboration within the Secretariat and across the UN system.

The Board is invited to note the report and provide guidance on future action with respect to WASH in health care and the process of mainstreaming WASH in health care into health programming and monitoring more generally.

This issue of mainstreaming patient safety, including WASH capacities and practices, into health system strengthening generally is critical. When health systems improve, they do so incrementally. Opportunities arise unpredictably in different locations, at different times and regarding different issues. Ensuring that such opportunities are grasped calls for leadership (technical, managerial, political), ongoing broadly based policy dialogue about priorities, and a movement for change, encompassing both the workforce and the wider community.

PHM urges MSs to ensure that future directions regarding patient safety, including WASH capabilities and practices, are embedded in a broader set of strategies directed to driving the dynamics of health system strengthening, including the role of civil society.

## 7.1 WHO reform processes, including the transformation agenda, and implementation of United Nations development system reform

### Contents

- [In focus](#)
- [Background](#)
- [PHM Comment](#)

### In focus

The Executive Board will be invited to consider a series of reports on WHO reform processes.

[EB144/31](#) provides an overview of the work to date on WHO Transformation, including information on the alignment of the transformation agenda with the reform of the United Nations development system, and implications for WHO's presence in countries and the planned direction and priorities for 2019. EB144/31:

- presents the case for change: the need for closer coherence across the UN system in terms of country-based work; the challenge of the SDGs;
- argues for priority to country based work and for closer alignment of the work of the three levels of WHO;
- promises a culture that will 'enable effective internal and external collaboration';
- promises a *'new approach to communications and resource mobilization, and bolstering partnerships, so that WHO is positioned to shape global health decisions and generate appropriate and sustainable financing'*;
- describes the 'approach to transformation' under Dr Tedros;
- explains how Secretariat processes are being redesigned;
- describes how WHO's 'operating model' is being aligned and optimised;
- describes how WHO's organisational culture is being optimised for 'collaboration, performance and impact';
- describes how UN reform, aimed at closer alignment of UN agencies at the country level, will impact on WHO's country work;
- describes organisational redesign work currently underway.

The Board is invited to note the report and provide further guidance.

[EB144/32](#) serves only to advise the Board that the Officers of the Board had found the 'prioritisation tool' (for prioritising items proposed for inclusion on the EB agenda), adopted for trialling in the lead up to EB144, to be time-consuming, of marginal utility and difficult to apply. The Officers of the Board suggest returning to previous criteria and processes.

[EB144/33](#) offers three options for interpreting or replacing gender-specific pronouns in the Rules of Procedure of the governing bodies.

[EB144/34](#) conveys the outcomes of informal consultations on governance reform (Geneva, 12 and 13 September, and 23 and 24 October 2018) in the form of the Chairperson's summary and proposed way forward. The Chairperson's summary and proposals deal with:

- A. Items proposed for the WHA agenda being considered by the EB to require a 500 word explanatory memorandum;
- B. New deadlines for submission of draft resolutions or decisions for the WHA or the EB to consider;
- C. Aligning references to 'NGOs in Official Relations' in the Rules of Procedure to the terminology of FENSA ("nongovernmental organizations, international business associations and philanthropic foundations in official relations ...");
- D. New guidelines for the posting of written statements from MSs in lieu of or as well as oral interventions;
- E. Possible measures governing the participation of NSAs in governing body meetings, including the possibility of an informal meeting with NSA outside of the GB meetings (elaborated further in the appended 'concept note');
- F. Possible measures regarding reporting on resolutions and decisions and for the rolling over of programs (initiatives, strategies, etc) the mandate of which has expired.

## Background

See [Tracker links](#) to previous discussions of WHO Reform

More background documents on the early WHO reform process can be found in a [2014-16 thematic guide](#) and [2010-14 chronology](#) on the MMI website.

## PHM Comment

### Transformation

The reforms described in [EB144/31](#) are explained in and perhaps obscured by a jungle of managerial jargon.

The reforms include a number of initiatives directed to "putting country outcomes at the centre of WHO's work, by aligning the operating model across all three levels for impact at country level" (para 4).

An example of increased country focus is "the systematic and strategic use of WHO's political capital to optimize national policy environments, enhancing WHO's role in identifying and scaling-up health innovations, and prioritizing and promoting a common research agenda" (para 17).

The initiatives being developed to strengthen country focus interrelate with UN level reforms directed to creating closer coherence across the work of UN agencies in countries, including a strengthening of the role of Resident Coordinator.

It is hard to make sense of some references in this report, in particular, the references to culture change and to 'agile' management practices and 'agile' product delivery teams. They

sound good but the document does not include any evidence or analysis regarding the prevailing culture as barrier (or how such culture is reproduced) or regarding 'less than agile' practices and teams.

One element of the reforms which is likewise obscure involves "taking a new approach to communications and resource mobilization, and bolstering partnerships, so that WHO is positioned to shape global health decisions and generate appropriate and sustainable financing" (para 4).

This new approach is not elaborated in EB144/31 but it may be reflected in the DG's introduction to the [Investment Case](#):

*Our agenda is ambitious – it must be. Too much is at stake for us to aim low. Like everything good, it comes with a price attached: US\$ 14.1 billion over the next five years. Many Member States and donors have stuck with us through tough times, and I hope this document will convince them to make even greater contributions – and new contributors to support our work.*

Presumably the new 'Partners' Forum' described in [EB144/43](#) (para 14) also reflects the 'new approach':

*Convening a Partners' Forum. The forum will build on successful experiences from WHO's Financing Dialogue, bringing together key contributors in order that they clearly understand the results to be achieved through WHO's Programme budget and identify solutions on how best to finance it. The forum would likely include sessions on further developing themes that were discussed during WHO's Financing Dialogue, including new mechanisms to allow a wider group of contributors to provide flexible funding, as well as newer themes, such as innovative financing by and partnership with the private sector.*

## Governance reforms

PHM supports the dropping of the 'prioritisation tool' and the requirement for a 500 word memorandum to justify proposed new agenda items.

On the question of gender-specific pronouns PHM urges MSs to support Option 3(c): to proceed with the required amendments to replace or supplement gender specific language in the Rules of Procedure of the governing bodies in all official and working languages of WHO's governing bodies.

PHM supports the implementation of the Chairperson's proposals under Items A-D and F in [EB144/34](#).

Item E ostensibly deals with "measures to stimulate the participation of non-State actors in official relations in governing bodies meetings". Some of these measures are unproblematic such as the option of posting comment on items two weeks in advance. However, the proposals to restrict speaking slots and speaking times appear more directed to restricting NSA participation than stimulating it.

However, we are particularly concerned regarding the proposal for an 'informal meeting' "bringing together Member States and non-State actors (nongovernmental organizations, international business associations and philanthropic foundations) in official relations" and

the Concept Note (in the Appendix to EB144/34) which elaborates this proposal. The objective of this ‘informal meeting’ would be to “allow for more interactions and more meaningful dialogue” and “would not replace current participation in WHO governing bodies, informal consultations and other forms of interaction”.

There have been several proposals for similar structures discussed - and rejected - over the last ten years.

The first was the Silberschmidt, Matheson & Kickbusch [2008](#) proposal for a WHA “Committee C” to operate alongside WHA Committees A and B. The rationale for a Committee C was to promote coordination across the various global health organisations including the International Health Partnership, the Gates Foundation, the GAVI Alliance, the Global Fund, UNAIDS, UN Population Fund, UNICEF, WHO, and the World Bank.

An apparently similar structure, Dr Chan’s World Health Forum (a “multi-stakeholder forum for global health”), was promoted as a key element of her WHO Reform initiative. As proposed in [A64/4](#) (May 2011), paras 86:

*The purpose of such a forum will be to increase engagement (particularly of those whose voices are less heard in current settings) and to increase trust. It should be problem-solving in orientation and seek to amplify important issues on which others, and not just WHO, may act.*

It was not clear from A64/4 just whose voices were judged to be “less heard in current settings”: NGOs, international business associations, other global health organisations or WHO’s donors.

This initiative was not supported by the Assembly but returned the following year in the Special Session of the EB on WHO Reform (see [EBSS/2/2](#) (Oct 2012), paras 88-91) as a revised multi-stakeholder forums proposal. The emphasis now was more clearly on private sector actors with examples citing the

*WHO Global Forum: Addressing the challenges of noncommunicable diseases, held in April 2011 before the Global Ministerial Conference on Healthy Lifestyles and Noncommunicable Disease Control in Moscow.*

and the

*Open-ended Working Group of Member States on Pandemic Influenza Preparedness: sharing of influenza viruses and access to vaccines and other benefits.*

This proposal was not supported by the EB (see [EBSS2\(2\)](#)).

The re-emergence of the World Health Forum as an ‘informal meeting’ in the Chairman’s summary ([EB144/34](#)) and the Secretariat’s concept note (in the Appendix to EB144/34) comes at a time when WHO has undertake or announced two other similar gatherings:

1. the first of these is the coalition of 11 global health organisations which developed the [Global Action Plan for healthy lives and well-being for all](#), structured around achieving the SDGs and especially the Health goals and anchored by WHO;
2. the new “partners forum” for WHO’s donors referred to above (and mentioned in [EB144/43](#) para 14).

Clearly the newly proposed 'informal meeting' is not designed for either the other major global health organisations or for WHO's donors.

It is hard not to speculate that the 'informal meeting' is in part a response to the pressures on the DG for greater engagement with the private sector and in part a strategy for helping to limit the time taken by NGOs during formal sessions of WHO governing bodies.

PHM urges MSs to not support this proposed 'informal meeting'.

## 7.3 Engagement with non-State actors

### Contents

- [In focus](#)
- [Background](#)
- [PHM Comment](#)

### In focus

In line with resolution [WHA69.10](#) (2016) and subparagraphs 68(a)(i) and 68(b) of the overarching framework of the [Framework of Engagement with Non-State Actors](#), the Executive Board will consider the annual report on engagement with non-State actors ([EB144/36](#)). The Board will be invited to consider a draft decision.

In addition, paragraphs 60, 61 and 64 of the overarching framework mandate the Board, through its Programme Budget and Administration Committee, to consider applications for admittance of non-State actors into official relations and to review collaboration with one third of the non-State actors in official relations in order to decide whether to maintain their official relations ([EB144/37](#)).

### Background

[Tracker links](#) to previous EB and WHA discussions of NSAs and FENSA.

Several recent initiatives dealing with WHO's relationships with NSAs:

- The UN Joint Inspection Unit has produced a report ([JIU/REP/2017/8](#)) on private sector partnerships in the context of the SDGs. It appears largely directed to facilitating such partnerships without regard to any possible risks.
- The "WHO-Civil Society Task Team" (managed as a partnership between the UN Foundation and RESULTS), was established in January 2018 at the invitation the DG, with the goal of enhancing collaboration between WHO and civil society organizations. Among other [recommendations](#), it calls for more support for policy dialogue: Build in explicit, accessible opportunities for civil society to provide input into policies and governance at all levels.
- UHC2030, a GPPP ("multi-stakeholder platform") promoting UHC, has created a Civil Society Engagement Mechanism ([here](#)) which is hosted by a large US not for profit consulting organisation / project contractor (Management Sciences for Health, see [donor support page](#)).

### PHM Comment

[EB144/36](#) is a fairly bureaucratic report on the implementation of FENSA. FENSA has been implemented; it is being bedded down. Engagements with NSAs are taking place including with CSOs, PSEs, academic organisations and philanthropies. Challenges regarding the operationalisation of the Framework are recognised and being worked through.

The Secretariat is developing an external relations strategy including a strategy for engagement with NSAs which will comprise principles and blueprints for different kinds of NSA.

[EB144/37](#)

- documents 7 NSAs who have applied to enter into Official Relations and whom the Secretariat recommends be accepted;
- lists 71 existing NSAs in Official Relations whom the Secretariat recommends be continued;
- lists four applications which the Secretariat recommends be deferred, including [CropLife International](#);
- lists for existing NSAs with whom the Secretariat recommends discontinuing Official Relations.

PHM reminds MSs that CropLife International is the international trade association of the pesticide manufacturers. The Secretariat proposes deferring with a view to clarifying the nature of any putative collaboration with WHO.

Clearly the pesticide manufacturers have an intense interest in IARC's determination that glyphosate is "probably carcinogenic" (although the Joint FAO/WHO Meeting on Pesticide Residues (JMPR) found that the possibility of residues in food did not pose a risk to humans).

## 8.1 Overview of financing and implementation of the Programme budget 2018–2019

### Contents

- [In focus](#)
- [Background](#)
- [PHM Comment](#)

### In focus

The Secretariat report ([EB144/43](#)) describes the current status of financing and implementation of the Programme budget 2018–2019.

It appears that in aggregate terms the PB18-19 will be fully funded, assuming that ‘projected funding’ is realised. However, two thirds of revenue will be tightly earmarked and “donor interest does not match the prioritization made by Member States” (para 7(c)). As a consequence some programs are over-subscribed but such funds are not available for transferring to underfunded programs such as NCDs.

The report refers to a new “resource mobilization strategic framework” targeting different donor categories, ‘innovative financing for revenue generation’, and ‘targeted resource mobilization efforts’. The DG is looking forward to a large increase in funding from ‘emerging Member State contributors’.

The report foreshadows the new Partners’ Forum building on the experience of the Financing Dialogue. The DG anticipates ‘new newer themes, such as innovative financing by and partnership with the private sector’. He is also looking at ‘new mechanisms to allow a wider group of contributors to provide flexible funding.

### Background

[Tracker links](#) to previous discussions of PB18-19

[WHO index page](#) for Planning, finance and accountability

[PB Portal](#)

### PHM Comment

The donor chokehold over WHO’s workplan remains in place.

The DG has chosen not to revisit (at least for now) Dr Chan’s demands for increases in assessed contributions.

Instead he is wooing two somewhat different categories of donor: ‘emerging member states’ and private sector. It maybe that being seen to be private sector friendly is insurance against significant cuts in US funding.



## 9.5 Human resources update, including on the global internship programme

### Contents

- [In focus](#)
- [Background](#)
- [PHM Comment](#)

### In focus

The report by the Secretariat will provide an update on the implementation of the Organization-wide human resources strategy ([EB144/47](#)). Among other things, it will provide information on the following: mobility, implementation of mandatory age of separation at 65, and prevention of sexual harassment. Lastly, pursuant to resolution WHA71.13 (2018) on reform of the global internship programme, the Secretariat will provide an Annex, describing the measures that have been put in place to operationalize the objectives of the resolution and giving details of the mechanism by which financial and in-kind support will be provided to accepted interns (EB144/47 Add.1).

### Background

### PHM Comment

## 10.1 Outcome of the Second International Conference on Nutrition

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### In focus

The report (in [EB144/50](#)) describes progress in policy development during the 2017–2018 at national and global level in relation to the outcome documents of the Second International Conference on Nutrition (ICN2) (see [Rome Declaration and Framework for Action 2015](#)) and the proclamation of the United Nations [Decade of Action on Nutrition](#).

The report also provides an update on the implementation of the 2016 recommendations of the [Ending Childhood Obesity Commission \(ECHO\)](#).

The report reviews a range of further nutrition related initiatives from WHO and other UN agencies and notes MS commitments to implement recommendations included in these.

More detailed data on nutrition policy are provided in the [Global Nutrition Policy Review 2016–2017](#) but only at the regional level. Country specific data are accessible (with difficulty) from [GINA](#).

[EB144/50](#) also sets out a number of areas where, in the view of WHO and FAO, intensified action is required.

### Background

[Tracker links](#) to previous documents and discussions regarding ICN2 and/or ECHO.

See also the [Public Interest CSOs and Social Movements Vision Statement](#) adopted at the Public Interest CSOs and Social Movements Pre ICN Conference in November 2015 and the [Social Movements Statement](#) issued by social movements attending the pre-conference.

### PHM Comment

The underlying purpose of this report is to strengthen the accountability of member states for the implementation of commitments made at ICN2 and in a range of more recent international gatherings summarised in para 12.

Detailed country level data on nutrition policy, programs, mechanisms and actions are provided in the WHO/FAO [GINA](#) database although it is not easy to access.

PHM criticisms of the Outcome Documents of ICN2 are worth revisiting ([here](#)). PHM was particularly critical of the voluntary nature of all of the commitments but supported the

development of national nutrition plans as recommended in the Framework for Action and highlighted the need to build the domestic constituency to drive the implementation of such plans.

The data summarised in [EB144/50](#) (and provided in more detail in the [Global Nutrition Policy Review](#) and in [GINA](#)) provide rich material for social movements and professional organisations to hold to account their governments for implementing or otherwise the (voluntary) commitments they made in Rome in 2015 and in other subsequent meetings, resolutions and declarations.

PHM was critical of the weaknesses of the Outcome Documents in relation to food systems (in particular, issues of food sovereignty and agroecology); the impact of the prevailing trade regime on food systems; and the lack of effective regulation of transnational food corporations. These remain key issues and largely beyond the scope of the official ICN2 outcome documents.

The Assembly's support for the report of the ECHO Commission was highly qualified. In decision [WHA69\(12\)](#) the Assembly 'welcomed' the report and asked the Secretariat to develop an Implementation Plan. In decision [WHA70\(19\)](#) the Assembly 'welcomed' the Implementation Plan and urged MSs to 'develop national responses', 'taking into account' the recommendations of the Implementation Plan. Nonetheless there is much useful material in the original report and the implementation plan and governments should be challenged to implement fully.

## 10.2 Evaluation: update

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### In focus

Report [EB144/51](#): (a) provides a brief progress update in respect of ongoing work and, specifically, an update on measures to take forward the organizational learning component of evaluation; and (b) outlines the scope of and framework for the review of 40 years of primary health care to be carried out in 2019.

[EB144/51](#) suggests that the Board note the report and consider the proposal for the review of 40 years of implementation of primary health care at country level. However, the Officers of the Board have listed this report under matters for information so it might not be discussed.

### Background

See [Tracker links](#) to previous discussions of evaluation.

### PHM Comment

#### Review of PHC

The decision to undertake an evaluation of primary health care arose at PBAC27 (reporting in [EB142/25](#) at para 32) and was endorsed in the 11th meeting ([PSR11](#), pp 17-21). It was initially simply 'an evaluation of the implementation of primary health care' but during the EB debate the Dominican Republic (supported by Brazil, Colombia, Iraq, Fiji, Mexico, Ecuador, Peru, Panama) urged that it be focused at the country level. The Dominican Republic said, "Every country should be evaluated and the results presented at the World Health Assembly in 2020, with a view to finding the most effective way of attaining universal health coverage".

A year later the Evaluation Office is proposing a review which will:

- (a) document global progress towards primary health care implementation, identifying achievements and success stories, best practices and key challenges encountered; and
- (b) make recommendations on the way forward in order to accelerate national, regional and global health strategies and plans for *universal health care/primary health care* and the Sustainable Development Goals.

This apparent conflation of PHC with UHC is very odd. See more detailed discussion of this under Item 5.5 UHC.

The evaluation will be based on a literature review and an online questionnaire to member states.

PHM urges the Evaluation Office to undertake further consultation regarding its methodology before proceeding.