Health for All Now!
People's Health Movement

Policy briefs on Important Issues before EB 144

Issued through the aegis of People's Health Movement's WHO Watch Programme

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**5.5 Universal Health Coverage (UHC):**

- **Primary Health Care Towards Universal Coverage (EB144/12)**
- **Preparation for the high-level meeting of the UNGASS on UHC (EB144/14)**

**Summary**

EB144 will discuss three reports concerning universal health coverage (UHC):

- Primary health care (PHC) towards universal health coverage (EB144/12),
- Community health workers (CHWs) delivering primary health care: opportunities and challenges (EB144/13), and
- Preparation for the high-level meeting of the United Nations General Assembly on universal health coverage (EB144/14).

In this section, only the reports on PHC (EB144/12) and on the preparations for the high-level meeting on UHC of the UN General Assembly (EB144/14) are discussed. The role of CHWs in delivery UHC is discussed separately in the next section of the Policy Brief.

The discussion will be held in light of the 40th anniversary of the Declaration of Alma Ata, marked by the Global Conference on Primary Health Care held in Astana in October 2018, and the UN High Level Meeting on UHC that is to be held in 2019, as decided by the United Nations General Assembly (UNGASS) in Resolution 72/139.[1] The intention of the reports is to renew the WHO's commitment to UHC and PHC, given their importance in achieving the Sustainable Development Goals (SDGs).

**PHM calls on Member States to remember the original intention on the Declaration of Alma Ata, and to insist on a human rights-based approach to realizing the right to health, which incorporates the redistribution of power and wealth within countries and between countries, instead of focusing on a vision of UHC and PHC within the limited framework of preventing financial hardship for patients.**

Member States' unwillingness to increase their assessed contributions, along with WHO's increasing reliance on voluntary contributions from philanthropic foundations and the private sector actors undermines its status as the key public institution for popularising comprehensive PHC. Member States should be strengthening a WHO that is free of vested interests, properly funded and able to carry out this mandate by increasing their assessed contributions.

**Key Issues and Recommendations**
**Primary Health Care for Universal Health Coverage**

EB144/12 is mainly focused on the Declaration of Astana,[2] the consideration of its potential role in reorienting health systems around PHC in Member States, and a

[1] United Nations General Assembly, *Resolution 72/139*. Adopted on 12 December 2017. http://www.un.org/en/ga/search/view_doc.asp?symbol=A/RES/72/139 [19 January 2019].
[2] Declaration of Astana, https://www.who.int/docs/default-source/primary-health/declaration/gcphc-declaration.pdf [19 January 2019].

number of accompanying documents, such as the Vision for primary health care in the 21st century[3] and Operational Framework Primary Health Care: Transforming Vision into Action.[4] The bulk of documents presented to EB can be interpreted as a positive step forward in WHO's work in the context of PHC. However, a few points concerning the Declaration of Astana and the linked documents are worth noting.

First of all, even though the vision of PHC in this context is more comprehensive in comparison to most WHO documents from the last decade, its role in the Declaration of Astana is still limited to a technical vision of pre-requisites necessary to achieve UHC. As PHM has warned repeatedly over the past years, in no case should PHC be subsumed under UHC, since it is a much more complex and broader concept than the latter. As part of a financial glossary which took over WHO's documents, UHC limits the vision of PHC to its fiscal and financial aspects. This ignores a key dimension of PHC, i.e. the pressing need to create a more equal society in order to achieve health for all.

For example, paragraph 14 of EB144/12 states that: " (…) one of the major areas of focus of the global community is achieving UHC, and PHC is a necessary foundation for this effort. UHC has several dimensions, including improving financial protection (…) and universal access to quality services, medicines and vaccines; PHC is critical for addressing each of these".

On the other hand, in the Declaration of Alma Ata, PHC is seen as one of the key steps the we need to take in order to achieve Health for All and, among other things "(…) forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community".[5]

**PHM calls on Member States to remember the original intention on the Declaration of Alma Ata, and to insist on a human rights-based approach that incorporates the redistribution of power and wealth, within countries and between countries, instead of focusing on a vision of UHC and PHC within the limited framework of preventing financial hardship for patients.**

Another problematic aspect of EB144/12 is the extreme importance given to the role of the private sector on the road to realizing both UHC and PHC. Paragraph 3 of EB144/12 reads: "The Declaration of Astana describes the ambition to deal effectively with current and future challenges to health, mobilizing all stakeholders – (…) agencies and funds, the private sector, faith-based organizations and others – around national policies, strategies and plans across all sectors, to take joint actions to build stronger and sustainable primary health care towards achieving universal health coverage". More specifically, a lot of space in the Operational Framework (OF) Primary Health Care: Transforming Vision into Action is dedicated to cooperation with private sector providers. It is more than worrisome that the OF chapter dedicated to cooperation with private sector providers defines at length what should be done in order to attract more

[3] World Health Organization and United Nations Children's Fund, *A Vision for Primary Health Care in the 21st Century: Towards Universal Health Coverage and the Sustainable Development Goals. Geneva, 2018.* https://www.who.int/docs/default-source/primary-health/vision.pdf [19 January 2019].

[4] World Health Organization and United Nations Children's Fund, *Operational Framework Primary Health Care: Transforming Vision into Action – Draft for Consultation*. Technical Series on Primary Health Care. http://www.who.int/docs/default-source/primary-health-care-conference/operational-framework.pdf?sfvrsn=6e73ae2a_2 [19 January 2019].

[5] Paragraph 6, *Declaration of Alma Ata.* https://www.who.int/publications/almaata_declaration_en.pdf [19 January 2019].

private sector partners in the organization and delivery of PHC, but at the same time remains silent when it comes to defining specific mechanisms and tools that will be used to monitor the private sector and ensure that it does not forfeit public interest in order to satisfy its ceaseless search for profit.

It has been proven over and over again that privatization of health care has negative impacts on accessibility and quality of care, and represents a great obstacle in achieving Health for All. It is therefore unacceptable that WHO should move towards strengthening ties with the private sector, and **we urge Member States to insist on an Operational Framework that will make clear that the principal responsibility for health care delivery and governing lies with Member States' governments, and to take great care to monitor and sanction the role of the private sector in health care, including on questions of conflict of interest**. As has been said in the Alternative Civil Society Astana Declaration on PHC: "An essential component of PHC is UHC which should be universalist, based on social solidarity and built on a unified public funded system, with most service provision through public institutions".[6]

PHM welcomes the intention, outlined in EB144/12 and related documents, to empower communities and strengthen their role in planning and delivery of health care. In paragraph 16, EB144/12 says: "The involvement of empowered people and communities as co-developers of services improves cultural sensitivity and increases patient satisfaction, ultimately increasing use and improving health outcomes. In addition, there is considerable evidence that health systems based on primary care services that are first-contact, continuous, comprehensive, coordinated and people-centered have better health outcomes". The intention of the Secretariat in this regard is commendable.

**However, it has to be pointed out that truly people-centered and democratic health systems cannot be imagined in a world marked by the level of inequality we are witnessing today. In order to fulfill plans put forward in the Declaration of Astana, we urge MS to take a stand against growing economic and health inequality by engaging in normative processes that will support the establishment of a sustainable and equitable economic order globally and nationally**, amongst other things by rejecting the currently dominant neoliberal paradigm and regulating financial flows and tax havens and evasion.

**Key Issues and Recommendations**
**Preparation for the high-level meeting of the United Nations General Assembly on universal health coverage**

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.

One of the most notable moments of this document can be found in paragraph 3 of EB144/14, which reads: "WHO continues to support this disease-oriented focus but notes the need to make space for additional challenges, in particular achieving universal health coverage and health system strengthening". In a way, it is reassuring

[6] http://phmovement.org/wp-content/uploads/2018/10/AlternativeCSAstanadeclaration11Oct.pdf [19 January 2019].

to see that after years of implementing a disease-oriented approach to work, the Secretariat seems open to moving back to the more comprehensive aim of building strong and resilient health systems capable of making PHC possible. This should be commended in every possible way.

Nevertheless, similarly to what has been said about community empowerment and participation, it should be noted here that a shift in approach in this part of WHO's work will not occur without significant revision of the present financial-oriented definition of PHC circulating in WHO documents at the moment, as well as changes in the approach to WHO's own financing. Unless WHO is able to move away from the current donor chokehold and dependence on earmarked contributions, it is difficult to imagine that it will be able to push forward such a significant move. Therefore, **we greet the announced shift towards health system strengthening, and urge MS to support it by taking consecutive decisions to encourage the implementation of a systematic effort to build comprehensive PHC.**

**5.5 Universal Health Coverage (UHC):**

- **Community health workers delivering primary health care: Opportunities and challenges (EB144/13)**

**Summary**

The Report by the Director-General highlights the importance of Community Health Workers (CHWs) for universal access to healthcare. The Report refers to the *WHO Guideline on Health Policy and System Support to Optimize Community Health Worker Programmes*, launched in October 2018, as a global policy framework for governments. [7] The Guidelines are an important and timely instrument that consolidates the evidence with regard to CHW programmes in the current context.

The DG calls on governments to use the Guidelines to assess the design and implementation of their CHW programmes. The DG calls on the EB to note the report and gives a few points for discussion (EB144/13, para 18). Considering the relevance of the Guidelines, **PHM considers that the original Guidelines document should be endorsed by the EB**, for instance through a Resolution, and that **progress should be reported to the WHA every three years**, along with other health workforce-linked Resolutions and in line with Resolution WHA69.19 (2016). This will show the political will of governments to strengthen CHW programmes, health systems, and gender equality.

The authors of the Guidelines recognise the paucity of robust written evidence with regard to the policy areas examined, as well as the limited participation of CHWs in the perception survey undertaken for the development of the guidelines. Peoples Health Movement (PHM) and Public Services International (PSI) have member organisations working closely with, or consisting of, CHWs. We bring the lived experience of our members to this important discussion.

**Key Issues and Recommendations**
**CHW programmes: government initiatives with community participation**

In EB144/13 it is implicitly assumed that governments are the ones designing and implementing CHW programmes. For instance, it recommends that CHW programmes "be defined within a holistic approach that considers optimal service delivery modalities" (EB144/13, para 15, first bullet point), adopt "service delivery models in which community health workers are assigned general tasks as part of an integrated primary health care team" (EB144/13, para 14, seventh bullet point), and that "countries should plan for their health workforce as a whole" (EB144/13, para 15, second bullet point). While in the majority of cases CHW programmes are government run, there are countries where CHW programmes, even large-scale ones, are run by the private or NGO sector. Such models fragment and, in the long run, weaken health systems.

Further, while the Guidelines identify the role of communities in selection and monitoring of CHWs programmes, the Report fails to highlight this aspect. Acceptability and accountability to the communities they serve is a central element of well-functioning CHW programmes.

7 World Health Organization, *Community-based Health Workers.* https://www.who.int/hrh/community/en/ [23 January 2019].

The Report should explicitly state that, as a policy, **CHWs programmes should be government run, with community participation in, at least, selection and monitoring**. This can be added to Paragraph 13, first bullet point.

**CHWs as agents of social change**

CHWs programmes were originally viewed as **both an extension of the healthcare system and agents of social change through community mobilisation within a Comprehensive Primary Healthcare** (CPHC) approach. Current programmes emphasize their technical and community healthcare function; essentially treating CHWs as auxiliary extensions of the formal healthcare system,[8] often within a selective primary healthcare approach. This change in perspective regarding the role of CHWs requires a more extended discussion.

**We encourage MS to discuss the role that CHWs can play in addressing the social determinants of health, including through intersectoral liaison and through community mobilizing. The function of CHWs can be much more than simply 'service providers'.**

**Gender equality and collectivisation**

The global health workforce is predominantly female, but women are concentrated in lower-skilled jobs, with less pay and at the bottom end of professional hierarchies.[9] For instance, in OECD countries low-skill long-term care is mostly performed by women, and in several Asian and African countries, Community Health Workers, the last worker in the healthcare chain, are predominantly, if not exclusively, women. As they work within their communities and provide the care that women have traditionally performed without pay, such as maternal and child care, CHWs are rarely remunerated at par with the legal wage and most often have highly informal employment conditions. Keeping such a large female workforce below the minimum wage also contributes to the gap in wage level along gender lines, where women are less remunerated than men for work with similar levels of qualifications and responsibilities.

The increase of remuneration of CHWs in Pakistan, known as Lady Health Workers (LHWs), to the level of the legal minimum wage was an important factor that enabled their families to meet basic needs. According to a recent survey in the province of Sindh, LHWs' income represents 69% of their households' income.[10] This income source has greatly contributed to the ability of LHWs' families to access more diversified and nutritious foods, utilities such as gas and electricity, and to meet medical and education costs. This Sindh-based study found that 83% of the LHWs' children go to school. However, erratic income is the major reason for children not attending – mostly the girls. The same study found that LHWs' households have a high incidence of major disease and consequently heath expenditures represent roughly 1/5 of all household expenditure. The remuneration of the LHWs thus contributes to fulfilling the social and economic rights of LHWs and their families, especially girls in the family. Further, another study finds that recognising LHWs as paid workers in the

[8] World Health Organization. *Community health workers: what do we know about them? Policy Brief* World Health Organization, Geneva (2007).

[9] International Labour Organisation. *Improving Employment and working conditions in health services*. Report for discussion at the Tripartite Meeting on Improving Employment and Working Conditions in Health Services, Geneva (2017).

[10] Muhammad, Q. *Impact of delayed wages on lady health workers in Sindh: an exploratory survey*. Public Services International, Workers Education and Research Organization, Faridabad/Karachi (2017).

public sphere contributes to overcoming the gendered division of public and private spaces as it provides opportunities for these women to perform roles in public spaces that are understood to be the prerogative of men.[11]

The change in the condition of LHWs was made possible by the creation of a collective, organised under the umbrella of a workers' association. In many countries, CHWs are not allowed to form trade unions as they are not formally recognised as workers.

EB144/13, paragraph 13, fifth bullet point mentions the need to consider the voices and perspectives of CHWs in considering and setting policies that affect them, through social dialogue. This point should be strengthened to **recognise social dialogue, including genuine collective bargaining, with workers' unions, as a mechanism for designing policies and improving the wages and working conditions of CHWs.**

**Adequate remuneration**

Across South Asia, large-scale CHW programmes were designed on the assumption of deploying a volunteer, non-remunerated workforce, despite a substantial and increasing workload. NGO-led CHW programmes are run on the basis of dependent self-employment, while large-scale government-led programmes were designed to provide limited financial or non-financial incentives. It is only after CHWs' organisations raised their voices that in some cases a monthly honorarium, and in other cases regular wages, were introduced.

Some CHWs are provided with financial incentives on the sale of basic medicines and selected health commodities to their community. Thus, the burden of CHWs' remuneration is passed onto the community. As a result, these CHWs perceive themselves as salesperson and not as healthcare workers or workers for the community. [12] Other CHWs are provided task-based incentives for each health outcome or health service related task performed. This remuneration only amounts for a fraction of the minimum wage. This does not only deny CHWs of their legal wage, but represents a large-scale subsidy by CHWs and their families towards the national health system.

Further, incentive-based payment to the CHWs distorts public health priorities against health outcomes that are hard to measure and services that are not incentivised. Sales-based incentives are an even more pernicious form of payment.

Paragraph 14, the fourth bullet point mentions the need for a "financial package commensurate with the job demands...". We recommend that this line be modified to say "**providing practising CHWs with regular remuneration, commensurate to the work conducted and in-line with the domestic legal framework governing minimum wages and basic conditions of employment. This can be complemented with incentives, as appropriate**."

[11] Inam, M. *Sexual harassment of lady health workers at office and field*. Non-standard work in the healthcare sector in South Asia Series, Public Services International, Workers Education and Research Organization, Faridabad/Karachi (2017)

[12] Ahmed, S.M. "Taking Healthcare where the Community is: The Story of the Shasthya Sebikasof. BRAC in Bangladesh," *BRAC University Journal*, Vol. V, No.1 (2008).

**Regularization**

The WHO Guidelines include recommendations with regard to both remuneration and formalisation of employment through a "written agreement specifying role and responsibilities, working conditions, remuneration and workers' rights".[13]

In countries where CHWs are considered as volunteers despite being deployed for a substantial amount of hours per day, there has been a recurring demand to be recognised as workers. This is for instance the case in India, Nepal, and in Pakistan prior to their recognition. Regularisation is a complex process. Existing experiences need to be collected and best practices distilled to provide pointers and advice for other governments interested in taking up this administrative challenge.

MS should request the **WHO to undertake case studies of regularisation process of CHWs, health workers and other relevant experiences to be collected and systematized.** This can be taken up as part of the Working for Health programme, a joint initiative with the ILO.

**Fiscal Space**

The document mentions the difficulties linked to limited fiscal spaces, often constrained by "excessive reliance on donor funding" (EB144/13, para 10). It also stressed that CHWs should not be seen "as a way to save costs or as a substitute for healthcare professionals" (EB144/13, para 13, third bullet point). It points to the need for the integration of capital and recurrent expenditure into a long-term, sustainable financing (EB144/13, para 15, fifth bullet point). The document points to the need for external donors to align their support to domestic policy needs and encourages them to support recurrent costs linked to CHWs' remuneration (EB144/13, para 16, first bullet point), which are often seen as unsustainable by donors.

However, this will not be sufficient, as long as fiscal space is not created within the national accounts. Progressive tax reforms are required to develop robust and sustainable health systems. For example, in 2013-14 the total funds released by the Indian central government for the CHWs programme, known as Accredited Social Health Activists (ASHA), was INR 6,86 billion (US$ 100 million). In comparison, the estimated loss of revenue due to corporate tax avoidance was US$ 47 billion.[14] Corporate tax avoidance costs developing countries dearly. Progressive tax reforms that increase the contribution of large corporations can contribute resources for funding a regularised CHW workforce.

MS should demand that the secretariat undertake a **systematic review of strategies for the expansion of fiscal space for health systems strengthening**, including case studies of successful models of sustainable long-term financing.

[13] Recommendation 8, p.49. https://www.who.int/hrh/community/en/ [23 January 2019].

[14] Crivelli, E., De Mooij, R. and M. Keen. "Base Erosion, Profit Shifting and Developing Countries," *FinanzArchiv: Public Finance Analysis*, 72.3 (2016)

## 5.5 Health, environment and climate change

### Summary

"Climate change, like other human-induced large-scale environmental changes, poses risks to ecosystems, their life-support functions and, therefore, human health".[15] Climate change directly and indirectly affects human health through the loss of biodiversity, heat waves, droughts, extreme rainfall and severe cyclones. It imposes an additional burden through the transmission of food-borne, water-borne, and zoonotic infectious diseases. Together, this will lead to an increase in forced global migration, political conflict, and housing, food and water insecurity.[16]

The adverse health effects of climate change are not distributed equally: states in the Global South, which have weak health infrastructure, are disproportionately impacted.[17] Vulnerable groups within these states – future generations, women, children, elderly people, the poor, indigenous peoples, and people living in coastal areas – will be particularly hard hit (EB144/15, para 7).

In an attempt to tackle these challenges more than 150 States adopted the Sustainable Development Goals (SDGs) at a special UN General Summit in September 2015, and in December 2015, a new climate change agenda was adopted by consensus by 197 states in Paris, France. The Paris Agreement entered into force on 4 November 2016,[18] but according to an OECD report published in September 2018 only 8 of the 150 countries that have ratified it are meeting their climate obligations.[19] We remain very far from achieving its main objective, which is to limit temperature increase to 1.5°C.

At EB144 two draft global strategies on climate change and health will be discussed. PHM welcomes these strategies but urges WHO and Member States to ensure that they are implemented in the context of more fundamental efforts to transform the dominant model of development in which the maximization of corporate profits routinely outweighs the need to promote human well-being and ecological justice.

### Key Issues and Recommendations

### A more nuanced analysis of the political, economic and social determinants of health and the ecological crisis

At EB144 Agenda Item 5.6 is dedicated to discussing strategies for addressing the health effects of the unfolding ecological crisis. Two documents have been tabled that relate to this agenda item, i.e. the *Draft WHO global strategy on health, environment and climate change: the transformation needed to improve lives and well-being sustainably through healthy environment* (a report by the DG) (EB144/15) and the *Draft global plan of action on climate change and health in small island developing states*

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[15] World Health Organization*, Climate change and human health - risks and responses. Summary*. https://www.who.int/globalchange/summary/en/index12.html [19 January 2019]

[16] World Health Organization, *Climate change and health: key facts.* https://www.who.int/news-room/fact-sheets/detail/climate-change-and-health [20 January 2019].

[17] World Health Organization, *Climate Change and Health.* https://www.who.int/news-room/fact-sheets/detail/climate-change-and-health [19 January 2019].

[18] https://treaties.un.org/pages/ViewDetails.aspx?src=TREATY&mtdsg_no=XXVII-7-d&chapter=27&clang=_en [20 January 2019].

[19] OECD, *Financing climate futures, Rethinking Infrastructure*, September 2018. http://www.oecd.org/environment/cc/climate-futures/synthesis-financing-climate-futures.pdf [20 January 2019].

(EB144/16). This policy brief mainly focuses on the first document (EB144/15).

The WHO's work in this area rightly acknowledges the multi-dimensional nature of the ecological crisis, and the fact that "technology can buy time, but nature's bottom-line accounting cannot be evaded. We must live within Earth's limits".[20] The Peoples Health Movement welcomes its call to secure the right to health by "transforming our way of living, working, producing, consuming and governing" (EB144/15, para 5).

However, **a more nuanced analysis is needed of the precise nature of the economic, political, and social dynamics – particularly the embrace of neoliberal capitalism, extractivism, and financialization in recent decades – that have led not only to a steady rise in global temperatures over the past centuries, but to the unraveling of "Earth's ecological and other biophysical life-support systems"**.[21]

Without understanding these structural determinants of health, the definition and scope of "transforming our way of living" remains opaque. As such, the risk remains that the health effects of the ecological crisis will be managed in an incremental fashion, in line with the equally opaque caution in paragraph 3 of EB144/15 that WHO and Member State interventions should be limited to "the part of the environment that can reasonably be modified".

**Oversights and blind spots in the draft strategies**

The norm-setting role of the WHO is vital in addressing the health effects of climate change. The Peoples Health Movement (PHM) thus welcomes WHO's recognition of climate change as a global challenge and the two draft global plans of action tabled at EB144, one for all Member States and one for small island developing states (SIDS). These plans have many commendable aspects: their focus on prevention, the ambition to address the social determinants of health, the increased efforts to integrate health in all policies, and a broader focus on managing global environmental challenges outside of climate change, notably electronic waste, nanoparticles, microplastics, and endocrine disrupting chemicals.

PHM urges Member States to support the *Draft WHO global strategy on health, environment and climate change: the transformation needed to improve lives and well-being sustainably through healthy environment*. However, at the same time we have several concerns with the plan that might undermine it's ambitions, which are laid out below.

**A binding global treaty on climate change and health:** at present, no binding treaties to protect citizens from the health effects of climate change. This year EB144 and the WHA has the opportunity to develop such a binding global agreement. **We urge Member States to start work in this area, either by developing a binding treaty based on the *Draft WHO global strategy on health, environment and climate change*, or by making a formal commitment to work towards such a binding agreement**.

**Include actions to divest from fossil fuels and institutionalize a circular economy:** PHM appreciates the WHO's "commitment to tackling overuse of natural

[20] World Health Organization, *Climate change and human health - risks and responses. Summary*. https://www.who.int/globalchange/summary/en/index12.html [19 January 2019]
[21] World Health Organization, *Climate change and human health - risks and responses. Summary*. https://www.who.int/globalchange/summary/en/index12.html [19 January 2019]

resources, large-scale waste production, and undue influence of vested interests going against public interests" (EB144/15, para 14). However, little effort is made to develop a plan of action that addresses a root cause of climate change: a global economy based on fossil fuels and overconsumption.
We are concerned that the ongoing policy of stakeholderization pursued by WHO will prevent a meaningful shift away from a system of production, distribution and consumption organized around the use of fossil fuels.

If WHO truly wants to tackle these challenges, it should reconsider its current policy of relying on donations from the private sector to bolster its budget, as this exposes WHO to conflicts of interest. **Member States should increase their assessed contributions and untied their voluntary contributions so as to allow WHO to be a true international public health organisation and to fulfill its constitutional mandate.** The use of fossil fuels undermines WHO's efforts to protect and promote health. **We urge the WHO and MS to divest from fossil fuels and to invest in clean and sustainable energy sources.** Additionally, **we suggest that Member States include additional indicators on efforts to reduce fossil fuel usage in their reporting on climate change and health**, **and on progress towards a circular economy.**

**Financial commitment to fund the global strategy:** the funding of the strategy has not been addressed. It is important for the WHO to secure financial commitments for funding this strategy, particularly from countries in the Global North. However, at present assessed contributions from Member States are insufficient, and voluntary contributions are limited and often earmarked. Additionally, many of the actions detailed in the Draft Strategy fall outside the scope of the WHO. We therefore suggest that WHO include guidelines for Member States on domestic-level interventions they could implement in order to raise additional financing for WHO's work on climate change.

More specifically, we urge Member States to institutionalize a tax on carbon emissions, and to propose an indicator to measure its impact, in order to encourage a reduction in the use of pollution fossil fuels and to raise additional revenue for efforts to manage the health effects of climate change. Environment and health should be placed over profit. A carbon tax would implement an (international) polluter pays principle.

**Promoting international solidarity by encouraging the transfer of technology, including clean and sustainable technology:** adaptation and mitigation policies will be difficult to sustain without international solidarity. In particular, **it is imperative that states in the Global North transfer clean and sustainable technology to developing states**. Technology transfer would fulfill two fundamental complementary objectives here, namely equitable development and the fight against the health effects of climate change effects. WHO should therefore take a strong stance in this regard and encourage such transfer and solidarity.

**Norm-setting to ensure that non-state actors and private companies adopt a human rights-based approach:** it is essential to ensure that the policies and activities of non-state actors and private companies are based on human rights principles and are environmentally sustainable. We **urge WHO and Member States to support the Human Rights Council's current efforts to develop a legally binding instrument on transnational corporations and other business enterprises with respect to human rights**. Such an instrument should protect the right to a safe, clean, healthy and sustainable environment. It should also protect the rights of states to amend or withdraw from Free Trade Agreements that have predictable and/or unintended adverse effects on human health and the environment.

**Defend the rights of peasants and indigenous people:** vulnerable populations are mentioned in the strategy, but indigenous peoples and peasants are not explicitly included in this category. Protecting the rights of peasants and indigenous peoples, their environments, and their know-how is central to a just approach to managing climate change and to learning about transformative "ways of living". To acknowledge and respecting the rights of these groups is therefore a fundamental action in the fight against climate change. **We urge WHO and Member States to recognize and respect the rights of indigenous peoples and peasants by specifically naming them as vulnerable population in the Draft strategy, and by acknowledging the recently adopted *UN Declaration on the Rights of Peasants and Other People Working in Rural Areas* in its work on climate change and health**.[22]

[22] La Via Campesina, *The United Nations Declaration on The Rights Of Peasants and Other People Working In Rural Areas – Information Note*, October 2018. https://viacampesina.org/en/wp-content/uploads/sites/2/2018/11/flyer-peasant-rights-oct2018_rev1.pdf [20 January 2019].

## 5.7 Medicines, vaccines and health products & 6.1 Pandemic Influenza Preparedness Framework

### Summary

Within the WHO, the debate on access to good quality, safe and affordable medicines have a long and complicated history and is usually centred around a number of key recurring themes: intellectual property rights and market-driven R&D mechanisms, national capacities for research and development, issues around regulation and harmonisation of medicines, and political commitment (or the lack thereof) of Member States in ensuring access to safe and affordable medicines.

During the upcoming EB144, the debate on medicines is set to progress down its course once again and will be based around a number of key agenda items, most importantly agenda items **5.7 Medicines, Vaccines and Health Products** and **6.1 Pandemic Influenza Preparedness Framework.** This policy brief analyses each of these items and provides **recommendations aimed at ensuring that Member States and WHO possess the legal authority and technical capacity to procure medicines at an affordable price.**

### Context

This agenda item addresses two separate issues: (1) access to medicines and vaccines; (2) the affordability and accessibility of cancer medicines. These two topics are supported by two different Secretariat documents (EB144/17 and EB144/18 respectively) and will be analysed separately in this policy brief.

The most recent debates on access to medicines were preceded by requests from some Member States to have a formal discussion within the WHO on the Final Report of the United Nations High Level Panel on Access to Medicines, which was published in 2016. The report included a number of key recommendations to address the challenges caused by high drug prices and the lack of needs-driven innovation. However, a substantial debate on the document was never held due to the opposition from countries with large pharmaceutical industries (most vocally the United States, Switzerland and Japan).

In the past, the issue has been addressed under an agenda item that would discuss both issues – the shortage of medicines and access to medicines – together. Some Member States saw this as an attempt of the Secretariat to cater for calls for the UNHLP discussion, while others regarded it as a ploy to dilute the debate on both of these issues.

In January 2018 the 142nd meeting of the Executive Board decided to address the issue of access to medicines and vaccines debates at WHO within a 'broad whole of supply chain canvas'. Following this meeting, the 71st WHA decided to request the Director-General to elaborate a 'roadmap report outlining the programming of WHO's work on access to medicines and vaccines, including activities, actions and deliverables for the period 2019 – 2023'.[23] This roadmap is to be submitted to WHA72 through EB144.

[23] World Health Organization, *Roadmap for Access 2019-2023: Comprehensive Support for Access to Medicines and Vaccines.* Informal Discussion with Stakeholders, 10 September 2018. WHO: Geneva (2018).

The document presented to the board, EB144/17, reports on the process the Secretariat has used to produce the draft roadmap and shares the draft roadmap itself. The Board is invited to consider this draft roadmap and to provide further guidance to the Secretariat ahead of the WHA72 in May 2019.

**The Draft Roadmap for Access to Medicines, Vaccines, and Other Health Products, 2019-2023**

The roadmap contains two main strategic areas of action for prioritization: ensuring the quality, safety and efficacy of health products; and improving equitable access to health products. Under each of the two strategic areas, the roadmap describes relevant 'activities' and puts forward specific actions and deliverables, i.e.

(1) **ensuring quality, safety and efficacy of health products** through regulatory system strengthening, assessment of the quality, safety and efficacy/performance of health products through prequalification, and the use of market surveillance of quality, safety and performance; and

**(2) improving equitable access to health products** through i) **research** and development that meets public health needs and improves access to health products ii) application and management of intellectual property to contribute to innovation and promote public health iii) evidence-based selection and fair and affordable pricing iv) procurement and supply chain management, and iv) appropriate prescribing, dispensing and rational use of health products.

**Key Issues and Recommendations**

Although the draft road map brings together a wide range of programmes and commitments that have previously been addressed separately, it contains oversights that require further attention. We wish to highlight the following:

***Transparency requirements***: in order to empower procuring entities in price negotiations and to prevent the public paying twice for the development of the same health technology, transparency in research & development is essential. Unfortunately, in the Roadmap there is no explicit mention of the need to share reliable information on the cost of the health technology[24] development, which reveals the relative roles of public and investor funding and the breakdown of funding across different stages of drug development.

***Public-Owned Pharmaceutical Manufacturing:*** when talking about transparency, 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 example EB144/17 para 45). Furthermore, public-owned pharmaceutical manufacturing is a way to address the current lack of innovation in areas where there is public health need but no commercial interest.

***Negative impact of high harmonisation standards:*** although there are several references to quality standards and regulatory burden, the Roadmap fails to highlight that the drive for harmonisation of standards through trade agreements is one of the main barriers excluding new market entrants (particular from low- and middle- income

[24]A health technology is the application of organized knowledge and skills in the form of devices, medicines, vaccines, procedures and systems developed to solve a health problem and improve quality of lives. WHO Definition

countries), as it is associated with increasingly demanding standards that do not necessarily have any safety benefits. Focus on quality should never be a barrier to access and availability of health products at an affordable price. This is a particular risk where private sector 'partners' from advanced manufacturing settings are involved in standard setting.

***No reference to the negative effects of TRIPS + provisions:*** in the section which talks about fostering innovation through appropriate intellectual property rules, there is no reference to TRIPS+ provisions in bilateral and plurilateral economic integration agreements. Such provisions impact negatively on access and affordability of medicines and vaccines, e.g. the introduction of data exclusivity acts as a barrier for generic production The WHO could take a stronger position in supporting Member States that wish to use TRIPs flexibilities as a tool to procure essential medicines at affordable prices.

***No reference to marketing regulations:*** to ensure that the profits of health technologies are reinvested back into the innovation process, it is important to ensure that there are stricter regulations around the marketing of health products, as well as the practice of share buybacks. Currently, pharmaceutical companies spend a disproportionate amount of revenue on marketing, which could be reinvested into research and development. In the Roadmap, under "Interventions that improve use of health products" (EB144/17, pg.18) there is no reference to such regulation. However,WHA60.16urges 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. Furthermore, to prevent the extraction of value out of health care systems, it is also important to redirect expenditure allocated for share buybacks into public health innovation.

Other problems with this draft include a lack of clarity surrounding budgets, timelines and the institutional division of labour for delivering on the roadmap. **The document contains no budget estimates associated with the deliverables and timelines.** PHM has been consistent in voicing criticism and concerns over the deliberate underfunding of WHO programmes in the past. **The freeze on assessed contributions and the tight earmarking of donor funds means the possibility that some deliverables may be funded while other with be left unfunded. We call on the Secretariat that budget estimates be included in further iterations of the draft so as to ensure the sustainability of efforts to increase access to good quality, safe, and affordable medicines and vaccines.**

**Regarding access to biotherapeutics the road map mentions access to biologics but is silent on the implementation of the World Health Assembly resolution of 2014 which calls for the updating the Guidelines for Marketing Approval of Similar bio Therapeutics Products (SBP) based on new scientific evidence.**

The **roadmap contains a limited set of targets and indicators** that is derived from GPW13. We believe the road map will require more indicators to capture all of the deliverables and milestones included in the roadmap. Furthermore**, it fails to specify the roles of different levels within the Secretariat – the roadmap provides no breakdown of what will be done in Geneva, the regional office or the country offices, nor how these different roles will be shaped. PHM urges the Secretariat to clarify these aspects of the roadmap.**

**Cancer Medicines**

EB144/18 conveys the executive summary of a more extensive technical report examining the relationship between pricing approaches and (a) the research and development of cancer medicines, (b) greater transparency in medicine pricing and governance, and (c) the unintended effects of policies aimed at regulating medicine prices. It is important to highlight that much of the analysis in this report also applies to pricing dynamics affecting the availability and affordability of medicines for other diseases. However, cancer medicines are distinct insofar as they "exceed the prices and costs of medicines used for treating other diseases" (EB144/18, para18).

The report discounts the notion that value-based pricing will necessarily reducing the price of new medicines (EB 144/18, para 11). It affirms that the research, development and production costs of medicines "may bear little or no relationship" to the prices of medicines as "[p]pharmaceutical companies set prices according to their commercial goals, with a focus on extracting the maximum amount that a buyer is willing to pay for a medicine" (EB 144/18, para 13). Significantly, the report argues that concerns that lower medicines prices will negatively affect future research and development are "misplaced" (EB144/18, para 30).

The report acknowledges that the relationship between greater transparency and medicines prices is unclear (EB144/18, para 37), but argues that a lack of transparency is inherently problematic as it "may conflict with the principles of good governance and confidential agreements may compromise clear lines of accountability…[and] may even lead to corruption" (EB144, para 36). More broadly, the report argued that institutional reforms such as "strengthening pricing policies at the national and regional levels", "improving the efficiency of expenditure on cancer medicines", "promoting cross-sector and cross-border collaboration for information-sharing, regulation and procurement", "managing factors that would influence the demand for cancer medicines" and "realignment of incentives for research and development" might increase access and affordability of cancer medications (EB144, para 41).

Additionally, "the judicious selection of cancer medicines and the rational application of access requirements with consideration of the specific health-system context can deliver better health outcomes to cancer patients for the available financial resources" (EB144/18, para 24). While such measures may be effective in reducing medicine prices, some evidence exists that they may also have the unintended effect of delaying or ultimately preventing treatment due to lack of access to medicines (EB144/18, para 25).

**Key Issues and Recommendations**

PHM recognises WHO's efforts to increase the affordability and accessibility of cancer medication. However, we wish to note three key shortcomings of the report. Firstly, **the report does not consider the broader governance capabilities that would enable the implementation of the pricing options listed.** Single payer health systems with publicly accountable payment arrangements are much more likely to have both the regulatory powers and the coherence of purpose needed to implement many of the more promising options listed.

Secondly, **the governance issue of private sector participation in various regulatory functions at national/international level, and the adverse effects this may have on access to medicines, is not identified in the report.** Related to this, **the report fails to explicitly address the issue of trade agreements that constrain governments' regulatory capacities** (e.g. through TRIPS Plus Provision, ISDS

provisions, higher than necessary harmonisation, etc.) and the ways in which these arrangements impede access to medicines.

Lastly, it is a shame that the **report does not refer to existing WHO programs and activities through which some of the pricing options listed are already being implemented**. Assurances are needed that such programmes and activities are operating efficiently and are being adequately funded and supported by the Secretariat. On the other hand, **potential options for reducing medicines prices that are currently not being progressed through WHO programmes and activities are not sufficiently explored or identified** in the report.

**PHM urges Member States to request the DG to undertake further work on the affordability and accessibility of cancer medicines, including a more systematic consideration of the necessary governance capabilities, implementation models, and WHO programs required for improving access and affordability of medicines, and to explicitly acknowledge that the issue of affordability and accessibility of medicines goes beyond a single disease area.**

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

The Pandemic Influenza Preparedness (PIP) Framework was developed due to a concern regarding inequities characterizing the Global Influenza Surveillance Network (GISN) – now the Global Influenza Surveillance and Response System (GISRS). Prior to the PIP Framework, countries shared influenza viruses with WHO linked laboratories, which then shared candidate vaccine viruses with vaccine manufacturers. However, countries did not always benefit from the vaccines produced through these arrangements. Following a series of discussions, the PIP Framework for virus and benefit sharing was adopted in 2011. It compels recipients of viruses to share benefits derived from them.

The implementation of the Nagoya Protocol under the convention on Biological Diversity has complicated the operations of the PIP Framework. The Protocol requires "case-by-case Prior Informed Consent and Mutually Agreed Terms"[25] before sharing pathogens, but leaves it to Member States to draft legislation and policies aimed at operationalizing this requirement. Uncertainty surrounds the scope and implementation of the Protocol, specifically whether the PIP Framework should be seen as a "specialized international access and benefit-sharing instrument" that supersedes the Nagoya Protocol.[26]

The current WHO discussions are aimed at introducing mechanisms to address "the challenges and uncertainties related to the sharing of seasonal influenza viruses that have emerged as countries implement the Nagoya Protocol" (EB144/23, para 25, OP(1)(a)). More specifically, EB144 has been asked to consider a draft decision aimed at amending footnote 1 in the Standard Material Transfer Agreement 2, in Annex 2 to the PIP Framework. The amendment aims to entrench the principle of benefit sharing by extending its sphere of application to companies that make indirect use of "PIP

[25] Intellectual Property Watch, *Nagoya Protocol Implications for Health, Flu Genetic Data on WHO Board Agenda.* http://www.ip-watch.org/2017/01/17/nagoya-protocol-implications-health-flu-genetic-data-board-agenda/ [19 January 2019].

[26] Intellectual Property Watch, *Nagoya Protocol Implications for Health, Flu Genetic Data on WHO Board Agenda.* http://www.ip-watch.org/2017/01/17/nagoya-protocol-implications-health-flu-genetic-data-board-agenda/ [19 January 2019].

biological materials" but do not "provide fair and equitable benefit sharing" (EB144/23, para 25, OP (2)).

**Key Issues and Recommendations**

PHM welcomes efforts to ensure implementation of the principles of access and equitable benefit sharing is extremely complex. We therefore **urge Member States to support the proposed amendment of footnote 1 in the Standard Material Transfer Agreement 2, in Annex 2 to the PIP Framework, as set out in the report of the Director-General on implementation of decision WHA71(11) (2018).**

## 6.4. Promoting the health of refugees and migrants

### Summary

Under Agenda Item 6.4, the EB will be discussing EB144/27, a report by the DG on the draft global action plan to promote the health of refugees and migrants, following decision EB140/9 and resolution WHA70.15. The document also relies on the New York Declaration for Refugees and Migrants,[27] as well as the recent Global Compact for Safe, Orderly and Regular Migration.[28] The EB is invited to note the report and to provide further guidance on the development of the draft global action plan, though there may also be a resolution on this topic.

### Key Issues and Recommendations

There are several things to note about the report. First, the global action plan is seen as part of WHO's cooperation with other UN agencies focused on the rights of refugees and migrants, such as the IOM and UNHCR. The report states that WHO sees its role in this cooperation as *"achieving universal health coverage (UHC) for refugees, migrants and host populations within the context of WHO's Thirteenth General Programme of Work, 2019–2023"* (EB144/27, para 7). In the context of human displacement being at an all-time high, it is hard to believe that focusing on securing UHC for refugees and migrants will be sufficient to protect their rights in the long run.

As noted in the PHM Comment on this agenda item in WHO Tracker, the document seems peculiarly oriented towards action by the Secretariat and leaves out any concrete propositions and obligations for Member States (MS).[29] This is particularly strange, as previous documents on this topic contain nothing that prevents WHO from devising and implementing interventions that would involve MS. From the point of view of PHM, WHO should take a bolder role in this context, and **formulate a plan that would take into consideration MS' responsibilities and their roles in the drivers of migration worldwide – especially when it comes to forced and involuntary migration.**

The fact that WHO is moving forward with the development of the plan, as well as the fact that it intends to protect the health of refugees and migrants through strengthening primary health care systems in the world, and the recognition of the precarious position of migrants in the field of labour (EB144/27, para 17), is commendable: "*Many migrants, particularly the low-skilled or semi-skilled, work in low-paid jobs that are dirty, dangerous and demanding. They often work for longer hours than host-country workers and in unsafe conditions but are less inclined to complain, and consequently may have worse work-related health outcomes. This is especially the case for migrants in precarious employment in the informal economy."*

On the other hand, unfortunately, the document does not make clear how exactly WHO intends to act in these fields. The proposed priorities and objectives remain true on a general level, but there is no sign of how they are intended to be addressed in light of WHO's own governance and financial problems. For example, the described health systems approach would be more than laudable, if it would be clear how WHO is planning to move away from the current disease-specific paradigm in the first place. This is a question that is related not only to this agenda point, but also to the documents

[27] http://undocs.org/a/res/71/1 [20 January 2019]

[28] https://refugeesmigrants.un.org/sites/default/files/180711_final_draft_0.pdf [20 January 2019]

[29] https://docs.google.com/document/d/1-iaAL1vV9tOysDmSCZPFlfbdfEKOu9s182FirxVAZZ4/edit?usp=sharing [20 January 2019]

on UHC in general.

Another point that must be highlighted is that EB144/27 refers to Social Determinants of Health of refugees and migrants (*Priority Action 4*), but at the same time ignores some of the most important structural causes of migration in this context – war and rising economic inequalities around the world. Priority Action 4 reads: "*Ensure that the social determinants affecting refugees' and migrants' health are addressed through joint action and coherent multisectoral public health policy responses"*. By omitting the aforementioned causes of migration, the document fails to address the responsibility of HICs from the European and North American regions that carry most responsibility for the catastrophic health status of many populations around the world, especially of refugees and migrants, through their continuous involvement in warfare and exploitation of resources in LMICs.

Regrettably, today we witness that these are the very countries that block refugees and migrants from entering their borders, disregarding existing international agreements and compacts on migration, as well as basic human rights. The deplorable actions taken by the US government towards migrants reaching the southern US border, the refusal of many European countries to offer safe harbor to ships rescuing refugees and migrants at sea, and the open violence migrants are facing by police and security forces on border crossing in the West Balkans, all show that HICs are still not prepared to answer for the effects of their foreign policies, making it unlikely that they will voluntarily engage in any action aiming at protecting the lives and health of refugees and migrants.

This has to be acknowledged by the WHO, and **WHO should insist that HICs shoulder most of the responsibilities in making refugees and migrants safe and protecting their health.**

Another point that should be commented on is the fascination with health information systems (HIS) and data collection (EB144/27, Priority Actions 2 and 6) from refugees and migrants, presumably to make it easier for them to access health care at different points of their route. However, in this case, it is clear that collection of health information can easily become a way of controlling refugees and migrants. Instead of focusing on HIS, WHO and MS would do better to give more space to health system development and strengthening, as that would allow more people to have access to health care, in a way that does not put them in an even more precarious position than the one they are already in.

**WHO's actions in this field should be focused on protecting the health of refugees, migrants and host populations through mechanisms of solidarity, not security**, and this can only be achieved if it defines a plan that defines a much larger accountability of MS and insists on building health systems appropriate for the health needs of all.

## 7.3 Engagement with non-State actors

### Summary

This section of the policy brief analyses the following agenda items for the purposes of understanding their impact on the WHO's engagement with non-State actors:

- 5.1 - Proposed programme budget 2020–2021
- 7.1 - WHO reform processes, including the transformation agenda, and implementation of United Nations development system reform
- 7.3 - Engagement with non-State actors

The WHO's constitutional mandate "to act as the directing and coordinating authority on international health work" is undermined by **insufficient assessed contributions** from Member States. This has been used to justify the **stakeholderization** of the WHO and facilitates **donor capture of the organization**. In turn, this endangers WHO's independence and central role as the public multilateral institution responsible for normative governance of global public health.

**The Secretariat's current agenda further entrenches these governance challenges through**:

- decisions not to request an increase in assessed contributions and to focus on broadening the donor base under agenda item 5.1,
- proposals to convene fora with non-State actors (NSAs) and donor partners under agenda items 7.1 and 8.1,
- its reliance on the Framework of Engagement with non-State actors (FENSA) as a basis for enhancing engagement as stated under agenda item 7.3, despite significant limitations in implementation, and
- its recommendations to enter into official relations with entities that pose a high risk of conflicts of interests.

**The People's Health Movement urges Member States to advocate for increasing assessed contributions to ensure flexible funding that will permit the rationalization of funds across the WHO and across health issues globally, rather than the current system, which permits public and private donors to control the global health agenda.** This independence is also necessary to prevent conflicts of interest and undue influence on WHO's normative functions by actors that yield considerable financial power, particularly given the challenges WHO faces in implementing FENSA.

### Agenda item 5.1 - Proposed programme budget 2020–2021

The WHO Secretariat's approach to financing, as articulated in 'A Healthier Humanity: The WHO Investment Case for 2019-2023'[30] and in the proposed budget and related documents (EB144/5, EB144/6, EB144/7) fails to address the chronic inflexible and inadequate funding of the Organization. It also further entrenches the donor chokehold on what is intended to be a public multilateral institution. Framing the WHO budget in terms of the investment case for health, value for money (EB144/6), and impact (EB144/7) perpetuates the perception that the primary financial challenge for WHO is

[30] World Health Organization. *A Healthier Humanity: The WHO Investment Case for 2019-2023*. Geneva: World Health Organization (2018).

efficiency, versus a chronic, and arguably strategic, underfunding via assessed contributions by Member States.

Articulating the investment case for the WHO represents a significant step in the stakeholderization of the WHO, demonstrated by the Secretariat's claim that "further efforts are required to broaden the donor base" (EB144/5, para 71). Specifically, the Secretariat has articulated output 4.2.3: "Strategic priorities resourced in a predictable, adequate and flexible manner through strengthening partnerships", in which they state that

> "[a] new external engagement model, in line with GPW 13, will bring together resource mobilization functions, technical programmes and communications at all three levels of the Organization in order to ensure an informed and coordinated approach through strategic interactions with Member States, donors, multilateral stakeholders, non-State actors and the general public." (EB144/5, p.67)

And that they will deliver this by

> "[l]everaging the enhanced external engagement model, including through enhanced strategic communication and targeted partnerships, the Secretariat will work towards broadening the Organization's funding base and increasing the flexibility and predictability of its financing." (EB144/5, p.68)

**Key Issues and Recommendations**

Based on the current burdensome grant structure within WHO, **there is no reason to believe that broadening the donor base will reduce the problem of inflexibility of funds**, and indeed it seems likely that it will further entrench this issue. The proposal to track progress via "increased donor and partner visibility on contributions" (EB144/5, p.68) may also contribute to inflexible, targeted funding as donors seek recognition and credit for their support of specific initiatives, contributing to the ongoing distortion of priorities within the global health agenda. By not requesting that Member States increase assessed contributions (EB144/5, para 73), the proposed budget maintains the status quo: an over-reliance on unpredictable earmarked voluntary contributions and a concomitant failure to secure sufficient core flexible funding. This pattern of funding permits donors to determine WHO's priorities.

Significantly, the WHO Director-General has affirmed the value of flexible funding by acknowledging that an increased reliance on flexible funding rather than targeted grants could render an increase in the WHO budget unnecessary.[31] Despite this, the proposals before the EB note that "all increases in the budget are to be met through voluntary contributions (...)" (EB144/5, para 73). This approach is shaped by Member States' sustained unwillingness to adequately increase assessed contributions and further consolidates the shift towards managerialism and stakeholderization of WHO's financing and functions.

The discourse of investments and returns, targeted outcomes and "a focus on measurable impacts" (EB144/5, para 2) undermines the norm-setting role of the WHO as the central multilateral health organization in the world. It promotes an instrumental

[31] Ravelo, J.L. 2018. *WHO needs $14B — here's how it plans to raise it*. Devex. https://www.devex.com/news/who-needs-14b-here-s-how-it-plans-to-raise-it-93799. [2 January 2019].

framing of health issues, rather than a holistic perspective on the political, economic and social determinants of health, since it is more difficult to demonstrate links between investments and outcomes in these upstream pathways to health improvement.

Indeed, it is disappointing that the indicators that will go into the Healthier Populations Index outlined in EB144/7 are largely behavioral 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. While we commend the Secretariat's aim in the Draft Proposed Programme Budget to "depart from a disease-specific approach to a more integrated and health systems-oriented approach to drive sustainable outcomes" (EB144/5, para 2), this is inadequate for addressing the broader determinants of health and is undermined by the focus on measurable outcomes.

**Increasing assessed contributions by Members States and re-directing the framing of WHO's programme of work and financing to emphasise its status as a publicly-funded multilateral institution is necessary to ensure the autonomy, integrity, and efficacy of the WHO.**

**Agenda item 7.1 - WHO reform processes, including the transformation agenda, and implementation of United Nations development system reform**

In general, the People's Health Movement commends reform processes aimed at greater coherence across the UN system and coordination across the three levels of WHO with a focus on country-level prioritisation in line with the UN development system reform. However, we note that much of the report (EB144/31) is articulated in terms of managerial jargon, such as references to cultural change and 'agile' management, without adequate explanation or analysis of purported existing challenges. Moreover, we note that while there may be some marginal gains in efficiency as a result of improved coordination across the UN agencies, it doesn't appear that the improved coordination will extend to addressing the fragmentation of development assistance for health arising from the multiple vertical PPPs and bilateral donors involved.

**We support the proposal in EB144/32 to discontinue the use of the proposed amended prioritization tool and the implementation of the Chairperson's proposals under items A-D and F in EB144/34.** However, we wish to express concern about the proposal under item E "(d) To consider continuing discussions on organizing an informal meeting with non-State actors in official relations" (EB144/34, para 9). We note that there have been a number of proposals for a similar forum in the past ten years that have not been pursued, such as a WHA Committee C[32], and a multi-stakeholder World Health Forum.

This proposal reflects the emphasis on 'external collaboration' and 'bolstering partnerships' articulated in EB144/31 and other documents (see section on Agenda Item 5.1 above), further demonstrating the agenda of stakeholderization promoted by the Secretariat. Without a clear sense of the intent and impetus for the proposed informal meeting, it could create opportunities for more engagement with private sector actors. Combined with the statement in EB144/34 that limitations on speaking slots for non-State actors could be considered (para 9.(b)), this may represent a shift toward informal interactions versus formal interventions with WHO. Given the capacity of the

[32] Silberschmidt et al. "Creating a committee C of the World Health Assembly," *The Lancet*, 371:9623 (2008): 1483-1486.

private sector - particularly business associations and philanthropic foundations - to influence and shape the agenda according to its interests, such an informal approach may represent a significant threat to the transparency of non-State actor engagement and inputs.

Moreover, the relationship between this informal forum and the Partners' Forum proposed under agenda item 8.1 (EB144/43) is unclear. The Secretariat has articulated the following as a milestone for resource mobilization foreseen for 2019:

> (a) 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.
>
> (EB144/43, para 14)

**Key Issues and Recommendations**

The informal meeting with non-State actors and the Partners' Forum represent significant risks for conflict of interest and the exertion of undue influence on WHO governance and the global health agenda by private sector entities. **We urge Member States to reject the draft decision: "(3) to request the Director-General to elaborate a report and make recommendations to be submitted to the 145th session of the Executive Board about an informal meeting or forum to bring together Member States and non-State actors in official relations" (EB144/34, p.2), and to provide guidance against convening a partners' forum as proposed in EB144/43 (p.5, para 14.(a)).**

**In guiding decisions on these and all matters related to WHO's norm-setting role within global health, Members States should enact the decisions set out by the Executive Board in the 2011 special session on WHO reform**, which stated that:

> (e) engagement with other stakeholders should be guided by the following:
>
> (i) **the intergovernmental nature of WHO's decision-making remains paramount**;
>
> (ii) **the development of norms, standards, policies and strategies, which lies at the heart of WHO's work, must continue to be based on the systematic use of evidence and protected from influence by any form of vested interest**;
>
> (iii) any new initiative must have clear benefits and add value in terms of enriching policy or increasing national capacity from a public health perspective;
>
> (iv) **building on existing mechanisms should take precedence over creating new forums, meetings or structures, with a clear analysis provided of how any additional costs can lead to better outcomes**;
>
> (EBSS/2/DIV/2, p.2, emphasis added in bold)

Finally, with reference to EB144/33, regarding amendments to replace or supplement gender-specific language in the Rules of Procedure of the governing bodies, **we urge Member States to choose option (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." (para 3) and advocate for the related draft decision Option 3.** To ensure gender equity, all language in WHO documents should be made gender-neutral, eliminating not only masculine-specific language, but any language that implies a masculine and feminine gender binary to the exclusion of non-binary persons.

**Agenda item 7.3 - Engagement with non-State actors**

The Framework for Engagement with non-State Actors (FENSA) emerged from a broader agenda of WHO reform grounded on the premise that WHO was ineffective and inefficient. This contention was used as a politically expedient tool to justify under-investment in WHO as a public multilateral institution, exercised through a 'freeze' on assessed contributions.
Hotly debated behind closed doors for 4 years, FENSA was finalized in 2016, at WHA69. While it could have established clear rules and guidelines for protections against conflict of interest and preservation of WHO's autonomy, FENSA instead entrenches the stakeholderization of global health governance, i.e. the view that WHO is one of many 'stakeholders' within global health policy-making.

Its provisions appear to be inadequate in protecting WHO against the **undue influence of non-State actors**.

Despite its flaws, FENSA is the primary reference document governing all relations between the WHO and non-State actors.

**Key Issues and Recommendations**

In May 2016, the 69th World Health Assembly adopted resolution WHA69.10 on the Framework of Engagement with non-State Actors, in which the Director-General was requested, inter alia, to fully operationalize implementation of the Framework within a two-year time frame and to report annually thereon to the Executive Board. **Document EB144/36** contains the 3rd annual report and **Document EB144/37** contains information on proposals for admitting non-State actors into official relations with WHO, and on reviews of the status of existing official relations.

The link between the WHO Secretariat's agenda of stakeholderization of financing and operations and its engagement with non-State actors is clearly indicated in document EB144/36, which states that

> WHO continues to engage actively with a broad range of non-State actors. Transforming partnerships, communication and financing is one of the operational shifts of the Thirteenth General Programme of Work, 2019–2023, adopted by the Seventy-first World Health Assembly. The "triple billion" goal of the General Programme of Work cannot be achieved without stronger and more systematic engagement with non-State actors. (EB144/36, para 2)

Within this context, the effective implementation of FENSA is crucial in ensuring that WHO's normative work and public health mandate is not undermined by conflicts of interest introduced through engagement with non-State actors. However, as highlighted by the Report by the Director-General on Engagement with non-State actors (EB144/36), there are significant limitations in its implementation. While we commend the Secretariat for acknowledging the challenges that exist in implementing FENSA, we do not believe that it is appropriate to claim that it "provides a firm basis for enhancing engagement" (EB144/36, para 3) in light of these challenges.

We note with particular concern the limitations on implementation when clarity has not been achieved on: how 'furthering the interests' of the tobacco industry should be interpreted; co-sponsorship of events with private sector entities with commercial interests in those events; the resources required for a due diligence and risk assessment system; and especially, defining "[t]he extent to which non-State actors can contribute to the Organization's normative work ... while at the same time balancing the risk that such actors will have an undue and unacceptable influence on the work of WHO." (EB144/36, para 5). These challenges highlighted in the Director-General's report clearly indicate the inadequacy of the FENSA to ensure the protection of WHO functions from conflicts of interest.

With regard to the Report by the Director-General on non-State actors in official relations with WHO (EB144/37), we have noticed the deferral of the decision on the review of **CropLife International**'s status as a non-State actor in official relations (p.4, para 17). CropLife International is the international trade association of pesticide manufacturers, and has interests that certain harmful pesticides are not consider carcinogenic. **We recommend that Member States accept the deferral of CropLife International, as it was recommended in 2018, and should not be allowed to enter into official relations with WHO based on conflicts of interest between the WHO's mandate to promote public health and the commercial interests of Croplife.**

Equally, **we urge Member States to ask the secretariat to provide the collaborative work plan details of the organizations that are up for renewal of official relations. Our analysis show that in some cases these plans raise conflict of interest issues. For instance, the collaborative work plan between WHO and the International Federation of Pharmaceutical Manufacturers and Associations (IFPMA) in the area of NCDs states " Support WHO in advocating for health system strengthening and access to care for breast cancer an diabetics, in particular increasing supply chain efficiency."Similarly, on vaccines IFPMA is to provide support for evidence generation on global vaccine market study and in regards with regulatory system strengthening it would work with WHO in supporting activities to foster regulatory convergence and harmonization. All these propose collaborative activities raise conflict of interest issues because they are linked to the business interest that this organization represent. Therefore it is important that renewal of IFPMA is stalled until this is resolved as per paragraph 52 of FENSA, it states "these plans shall be free from concerns which are primarily of a commercial or profit-making nature"**

Finally, we wish to recall that **Resolution WHA69.10 requested the DG to conduct an initial evaluation in 2019 of the implementation of the Framework of Engagement with non-State Actors and its impact on the work of WHO with a view to submitting the results, together with any proposals for revisions of the Framework, to the Executive Board in January 2020**, through its Programme Budget and Administration Committee. Such an evaluation is key to determining whether FENSA meets its objectives. **It should be conducted in an independent**

**and transparent manner, and address the identified flaws and implementation challenges.**