

PHM Statement on WHO's draft Global Program of Work for 2019-23 (GPW13)¹

13 Nov 2017

WHO's Executive Board (EB) will meet in special session on 22-23 November to consider the proposed 13th General Program of Work (GPW13). (This is the fourth special session of the EB, hence EBSS4.)

The GPW is the highest level planning document of WHO and sets out the policies and priorities which will frame the biennial programme budgets which it encompasses. It is proposed that GPW13 will span the period 2019-23.

A [consultation paper](#) was published in August 2017 discussed by regional committees and opened for public feedback. The first full draft [GPW13](#) (plus the more detailed [Impact Framework](#)) was published at the beginning of November. The GPW13 draft also promises a forthcoming 'investment case' which presumably will be published in time for the EBSS. The draft also mentions that quantitative methods for impact accounting are being explored; presumably also scheduled for publication before the EBSS.

It is intended that GPW13 is to be adopted by the World Health Assembly in May 2018 (WHA71).

In addition to its direction setting function this GPW also serves to affirm and underpin Dr Tedros's authority as the new DG. It differentiates his leadership from that of Dr Chan and offers a newly polished vision which might shore up the confidence of member states and re-inspire WHO staff and the wider public health community. Importantly it supports the case for loosening the donor chokehold on WHO: lifting the freeze on assessed contributions and untying voluntary contributions.

The proposed 'new' vision however contains within it imprints of the existing deficiencies in WHO's work which stem from the donor chokehold on WHO and the dominant neoliberal framing of health development challenges and organisational policies – often aggressively pushed especially by rich member states of the North.

Financial crisis

In May 2017 the World Health Assembly was advised ([A70/6](#)) of a \$500m shortfall in the programme budget for 2016-17. The emergency fund set up after the Ebola crisis was also seriously under-subscribed.

The program budget for 2018-19 ([A70/7](#)) envisages an annual budget for WHO of around \$2,200 million. This is around 30% of the annual budget of US CDC, 4% of Pfizer's and Unilever's annual turnover; and around 10% of Big Pharma's annual advertising in the US. It is simply not enough for WHO to properly fulfil its responsibilities in global health.

The proper response to the funding crisis should be an increase in assessed contributions (ACs, mandatory member state contributions). In Jan 2017 (EB140) Dr Chan proposed a 10%

1. This (draft) comment is taken from PHM's WHO Watch platform ([here](#)). See also PHM's WHO Tracker for [EBSS4](#).

increase in assessed contributions for the 2018-19 biennium but following opposition from certain member states this was reduced to 3% for PB18-19.

The purpose and effect of the freeze on ACs is continued dependence on donor funding and continued donor control over WHO's program of work. See [PHM comment on donor control in relation to the Programme Budget for 2018-19 \(PB18-19\)](#). An essential part of the donor control strategy is tight earmarking of almost all donor funding. Virtually all WHO's programmatic expenditure is funded through donor funds. Strategies which are endorsed by the Assembly but which donors do not like, do not get implemented (most notoriously the failure to implement the 2006 Trade and Health Resolution, [WHA59.26](#)).

The draft GPW is largely silent on WHO's financial crisis and eschews any reference to the donor chokehold.

WHO will strengthen its approach to resource mobilization: Resource mobilization will be a team effort between Member States and the Secretariat – there will be no “us and them.” WHO will advocate for the bigger envelope of health funding of which WHO is just a part. The focus on impact will strengthen the case for investing in WHO. Value-for-money will be shown by clear measures of cost-effectiveness.

It appears that the new leadership hopes the new GPW, with its focus on country level work, and universal health cover (UHC), the sustainable development goals (SDGs) and emergencies will help to shore up the confidence of member states and perhaps build support for lifting the freeze on assessed contributions, broadening the donor funding base and untying voluntary contributions.

There is no reference in the draft GPW to the 'financing dialogue' through which the Secretariat meets with WHO's donors to try to persuade them to fund the various programs and initiatives endorsed by the Assembly. The funding dialogue effectively institutionalises donor control of WHO's operational budget; budget proposals are offered for sale and if no buyers those programs will not proceed.

The donor chokehold over WHO's finances is the most critical challenge to be addressed in GPW13. The only practical solution is a substantial increase in the level of assessed contributions.

PHM calls on member states to recognise the importance of WHO's work and the human cost of the continuing donor chokehold and to commit to a schedule of increasing assessed contributions by 5-10% in each of the next three biennia. In view of the massive expenditures on armaments, the obscene wealth of the 1% and the pervasiveness of tax avoidance it is self-evident that the barriers to the proper funding of WHO are political – to maintain donor control – rather than an aggregate lack of resources.

Operational priorities

The opposition to Dr Chan's call for a 10% increase in ACs in Jan 2017 was accompanied by dark warnings about priority setting and fiscal discipline. The Secretariat responded with the 'Value for money' strategy (elaborated in [A70/INF./6](#)) which foreshadowed a further round of cuts and 'efficiency savings'. In resolution [WHA70.5](#) the DG was asked ... "to

control costs and seek efficiencies, and to submit regular reports with detailed information on savings and efficiencies as well as an estimation of savings achieved.”

The draft GPW seeks to navigate between the need to produce a forward looking inspirational document and the pressures to prioritise and reduce the level of ambition. The GPW gets around this problem by adopting a broad understanding of UHC (including pharmaceuticals policy), highlighting emergency preparedness and support for the SDGs and by adopting the priorities established for the Agenda 2030 in the shape of the ‘health related SDGs’. However, lest the accusation be raised that the program lacks the required discipline, the GPW promises that:

WHO will focus on the strategic priorities of UHC and health emergencies, and will also establish “flagships” to address key issues such as climate change in small island States, antimicrobial resistance, noncommunicable diseases including mental health, and human capital.

The GPW is structured around the goals of UHC and the SDGs. PHM urges the new leadership to make space for a more critical approach in both of these areas.

WHO has in the past promoted a narrow vision of UHC as ‘financial protection’. While financial protection and rapid reduction in out-of-pocket expenses is a necessary condition for universalisation of secure access to comprehensive health care services, it needs to be accompanied by significant scaling up and continued support for delivery of healthcare through public provisioning. The GPW is entirely silent about the role and importance of public services in healthcare.

PHM appreciates the acknowledgement (p7) that UHC needs to be based on primary health care (PHC) but this needs further elaboration given the ambiguity regarding WHO’s position on selective primary health care vis a vis comprehensive health care. Several of WHO’s large donors would reduce “PHC” to the delivery of a ‘basic benefit package’.

The GPW has only one reference to the need to develop and sustain health workers, and no proposal to follow up on WHO’s work on the regulation of health worker migration, especially as regards to responsibilities and obligations of importing countries in the global North.

The GPW’s unquestioning acceptance of the SDG framework papers over critiques suggesting that the laudable SDG goals may be unattainable given that they are premised on the same neoliberal model – increased unsustainable consumption and economic growth, driven by a liberalised trade regime. The GPW is silent about the impact of contemporary ‘free trade’ agreements on health or on the threats to healthcare and to population health associated with market power and self-interest of transnational corporations in diverse sectors including pharmaceuticals, food and beverages and mining.

The GPW appears to promote a charity model of health development through its several references to the ‘vulnerable’ and ‘hard to reach’ people who need support. **It is imperative that the larger vision of the WHO be informed by a rights based approach that incorporates the redistribution of power and wealth, within countries and between countries.**

Inverting the pyramid.

The draft GPW promises to place countries squarely at the centre of WHO's work with training and recruitment initiatives directed to an upgrading of the role of WHO's country representatives, a new 'operating model', further investment in country relevant information and enhanced country cooperation strategies. This commitment echoes similar commitments from previous directors-general but it has proved very difficult to achieve.

PHM appreciates the references to closer engagement with civil society at the country level.

By fostering citizens' participation, civil society dialogue and by interacting with governments including parliamentarians, finance ministers, and Heads of State, WHO will advocate for domestic investment in the health workers, infrastructure, supply chains, services and information systems that underpin the health sector, including by providing evidence of the broad benefits of such investment. (p9)

Key priorities include: ... at the country level, strengthening WHO's cooperation with, and convening of, partners including with United Nations partners (in line with the Secretary-General's initiatives to reform the United Nations development system), bilateral and multilateral institutions, academic institutions and civil society to promote health in the sustainable development agenda (p22).

Civil society mobilisation is an important driver of health development, locally, nationally and globally and the caution of country offices in engaging with local civil society has been a significant weakness in WHO's country work.

PHM also appreciates the commitment to 'drive impact in every country'. The draft recognises that the focus of country engagement will have varying emphases on policy dialogue, strategic support, technical assistance and service delivery depending on the capacity and vulnerabilities of particular countries. However, "WHO will strengthen its role in driving policy dialogue in all Member States" (p16).

Certainly there is an urgent need for a more challenging and robust debate regarding global health policies and priorities, including in the rich countries. However, the reasons this function has been weak in the past are related to the accountability structures within which WHO Representatives (WRs) and regional directors (RDs) work, both of whom are constrained by the sensitivities of, and sanctions available to, member states through the regional committees. There are no structural proposals offered which might empower WRs and RDs to engage in challenging and robust policy dialogue or to engage with civil society organisations (CSOs) in developing such dialogue.

From outputs to outcomes and impacts

PHM appreciates the commitment in the draft GPW to more meaningful metrics for assessing the outcomes and impacts of WHO's work.

WHO has been under continuing pressure to cost and measure outputs and outcomes. Often such urgings are embedded in a narrative of alleged inefficiencies, opacities and lack of accountability; a narrative which is designed to justify the freeze on assessed contributions. WHO should not be driven by such self-serving arguments.

The draft GPW promises that:

Moving beyond a focus on process or outputs alone, WHO will place the impact on people at the heart of its work. WHO will measure its results and detail its contribution, in support of countries and alongside other actors, to outcomes and impact.

In the complex adaptive global system in which WHO works, a linear scheme of inputs, activities, outputs, outcomes and impacts is overly simplistic, notwithstanding the recognition of the 'combined contribution of WHO, member states and partners'. Health development strategies are implemented amidst a swirl of contemporaneous dynamics, economic, political, cultural and environmental. A 'theory of change' which recognised this complexity would also recognise the powerful role played by civil society organisations and the changing climate of community sentiment (clearly evident in relation to climate change and food systems).

However, moving the emphasis from measuring 'outputs' to 'outcomes and impacts' brings to the fore the question of attribution: who contributed what to measured outcomes?

Responding to this the draft GPW comments (p21):

As progress depends on many joint actions by WHO and its governmental, civil society and private sector partners, specific attribution to each party is less important than achieving impact and building confidence about the contribution of WHO to that mutual success. WHO's contribution is detailed in the draft GPW 13 and also in the accompanying WHO Impact Framework. WHO will include qualitative country success stories in its scorecard and its results will be externally reviewed by an independent panel.

It appears that the attribution question will be managed through greater and more systematic use of qualitative narratives, supported by quantitative data where appropriate. The Secretariat has previously been under great pressure to produce quantitative indicators spanning the full 'results chain', even where such indicators are clearly meaningless. The affirmation of the value of qualitative data in teasing out attribution is welcome.

One of the most critical steps in the results chain in PB18-19 ([A70/7](#)) are the so-called 'deliverables', which have been largely ignored in the rush to measurement. Systematic reflection on the quality, efficiency and impact of 'deliverables' is critical in strengthening organisational learning across WHO. The 'deliverables' get to the heart of what the staff and programmes of WHO do on the ground, day by day. Accountability to the governing bodies should not get in the way of organic action research and action learning at the workplace.

Missing from the discussion of new metrics is the challenge of member state accountability, the lack of which has been a significant weakness of WHO. The draft GPW comments:

Several actors contribute to the impact described here, notably Member States themselves, and there is collective accountability and credit for impact. WHO's role is catalytic and is clearly stipulated at the outset in qualitative terms for each target in the draft WHO Impact Framework. Quantitative methods for impact accounting are being explored; applying these would go beyond the current standard of practice in accounting for impact in global health. Moreover, these global targets will serve as the basis for specific region- and country-focused strategies.

It is not clear what this commitment will mean in practice but it should involve strengthening the accountability of member states. Hopefully the next iteration of the GPW will clarify this passage.

The reference to 'partners' in the above quote is open to different interpretations. WHO's partners have variously included intergovernmental organisations (such as UNICEF, UNDP and the World Bank), large philanthropies (such as Gates and Rockefeller), international business associations (eg the IFPMA), corporations (eg vaccine manufacturers), and various civil society organisations (including public interest CSOs such as IBFAN, HAI). In this context two issues stand out: first, the continuing pressure on WHO to extend the use of the 'multi-stakeholder partnership' model of program design (with a view to giving corporate 'partners' a 'seat at the table'); and second, the very cautious approach hitherto adopted by WHO country offices to collaboration with local civil society organisations.

Some of the 'multi-stakeholder partnerships' involving WHO working with private sector entities includes the notorious IMPACT initiative with Big Pharma ([Shashikant 2010](#)), and SUN and REACH in the nutrition arena ([Valente 2015](#)). The draft GPW comments that:

WHO cannot accomplish the ambitious targets of GPW 13 without partners from all sectors including civil society and the private sector. It can also serve as a catalyst for partnerships between non-State actors and government. Therefore WHO will need to ensure that the Framework of Engagement with Non-State Actors is implemented in such a way as to enable partnerships, while protecting the integrity of the Organization.

PHM urges the new leadership to treat with caution the continuing pressure to adopt the 'multi-stakeholder partnership' model of program design especially where it involves inviting the foxes into the chicken coop. The framework for engagement with non-state actors (FENSA, [WHA69.10](#)) provides principles and protocols for the management of potential conflicts of interest, including those associated with 'multi-stakeholder partnerships' but it remains to be seen how effective these protocols will prove to be. (See [Legge 2016](#) for more detail and references.)

The FENSA is focused solely on decisions taken within the Secretariat and does not address the accountability of member states. There have been notorious lapses in member state accountability including the IMPACT controversy; the psoriasis resolution proposed by Panama in the EB133 (May 2013) and adopted in May 2014 in WHA67.9 ([PHM comment here](#)); and the Italian intervention on behalf of the sugar/chocolate industry in EB137 (May 2015) ([PHM comment here](#)). A core weakness of WHO is the lack of domestic accountability of member states for their contribution to WHO's work and their implementation of agreed policy directions.

Of comparable importance is the lack of accountability of regional committees and regional directors, an issue which has been commented upon repeatedly by the UN's Joint Inspection Unit ([JIU/REP/93/2](#), [JIU/REP/2001/5](#), [JIU/REP/2012/6](#)). Hopefully the new GPW will signal further steps towards 'alignment' and 'harmonisation' across regions and strengthened regional accountability.

A more structured, more strategic 'foreign affairs' capacity.

PHM applauds the recognition of the need for a more structured, more strategic 'foreign affairs' capacity in the secretariat and strengthening the capacity of WHO at all levels for multisectoral action.

Of course WHO has always maintained relations with other intergovernmental organisations and processes but largely hidden from view in the DG's office. Formalising and strengthening WHO's foreign affairs capacity (and affirming its importance at the regional and country levels) would be particularly appropriate having regard to the health implications of all of the 'non-health' SDGs and would build on WHO's previous experience with initiatives such as Healthy Cities and 'Health in all Policies'. Figure 1 in the new PB18-19 ([A70/7](#)) highlights the significance, for WHO's health priorities, of the various 'non-health' SDGs (goals for which other intergovernmental agencies have coordination responsibility). A stronger foreign affairs capacity in the WHO secretariat would greatly facilitate WHO's engagement in progressing these goals, including their health related aspects.

A more structured approach to intersectoral engagement should also prioritise intensive industrial animal husbandry (with implications for climate change, antibiotic resistance and nurturing pandemics); land grabbing (with implications for nutrition, deforestation and livelihoods); tax avoidance and tax competition associated with foreign investment; chemicals control; and air pollution; all 'non-health' SDGs with significant health implications. In this regard the work program could usefully build on previous WHO work on the social determinants of health and in particular the work of the Commission on the Social Determinants of Health. The GPW is silent regarding WHO's earlier work on the social determinants of health.

PHM appreciates the emphasis on access to medicines as part of UHC (p8). However, several of the most critical issues are either ignored or referred to in the most indirect way. These include:

- support for countries to preserve and utilise TRIPS flexibilities in accordance with [A59.26](#);
- proposals for delinking the price of new medicines from the cost of R&D through an R&D treaty as recommended by the [Commission on Innovation, Intellectual Property and Public Health](#); and
- strengthened medicines regulation, including action on substandard and falsified medicines (see most recently the annex to [A70/23](#)).

The absence in the GPW of any direct reference to IP barriers to access appears to reflect the continuing pressure from 'Big Pharma', including via their countries of origin, to prevent WHO from addressing IP related issues.

Action around trade, NCDs and the social determinants of health has been consistently underfunded in the last three biennia reflecting the donors' opposition to any kind of regulatory response to these challenges. Meanwhile, however, under the aegis of the Human Rights Council, proposals for a global treaty directed to regulating transnational corporations and other business enterprises is under development. Official consideration of this initiative is carried in the [open-ended intergovernmental working group](#) but there is a network of public interest civil society organisations campaigning around curbing corporate

impunity (see <https://www.stopcorporateimpunity.org/>). WHO should be engaging in this debate. The effective regulation of TNCs is not going to be achieved easily but it will be critical to addressing the challenges associated with NCDs, SDH, pharmaceuticals and many other issues which are central to WHO's mandate.

In this context the references (in the draft GPW) to 'focusing global public goods [normative functions] on impact' are intriguing, given the explicit inclusion under WHO's normative functions of binding agreements as well as guidelines and technical advice. One of the reasons the rich countries are so determined to maintain the donor chokehold over WHO is the potential significance of the Organisation's treaty making powers (as exemplified in the successful Framework Convention on Tobacco Control). Previous (less successful) debates around the strategic use of WHO's treaty making powers have focused on the marketing of breastmilk substitutes and the 'ethical' promotion of pharmaceuticals. In the present era the potential application of these powers to food labelling, sugar and fat taxes and an R&D treaty underlie the determination of the TNCs and their nation state sponsors to maintain the donor chokehold.

In summary

PHM is fully committed to the Constitution of WHO, appreciates the forward looking character of the draft GPW and stands ready to work with WHO under its new leadership in a renewed effort to achieve Health for All. PHM urges the Secretariat and Member States to strengthen the GPW, taking into account the concerns raised in this commentary.