



*Health for All Now!*

**People's Health Movement**

## **Policy Briefs on Important Issues before EB 142**

Issued through the aegis of the People's Health Movement's  
([www.phmovement.org](http://www.phmovement.org)) WHO Watch Programme

Refer to our detailed Commentary on the entire agenda of WHA 70 at  
<http://who-track.phmovement.org/eb142>

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### 3.3: Public Health Preparedness and Response

#### Background:

The Board will consider the third report of the Independent Oversight and Advisory Committee (IOAC) of the WHO Health Emergencies Programme (HEP), presented in **EB142/8**.

**EB142/9** reports on WHO’s work in health emergencies, updates previous reports on coordination and response in large-scale emergencies, and reports on the development of the Research and Development Blueprint for Action to Prevent Epidemics for potentially epidemic diseases.

**EB142/10** presents a draft five-year global strategic plan to improve public health preparedness and response, based on the guiding principles contained in Annex 2 to A70/16, as requested in decision WHA70(11).

The reform of WHO’s emergency capabilities is depicted in the following Table:

WHO initiatives for Global Health Security since 2015	
<b>WHO reform</b>	<ul style="list-style-type: none"> <li>- <a href="#">WHO Health Emergencies Programme</a> (unify WHO’s emergency functions)</li> <li>- Establishment of the <a href="#">Independent Oversight and Advisory Committee for the WHO Health Emergencies Programme</a></li> </ul>
<b>Global Emergency Workforce</b>	<ul style="list-style-type: none"> <li>- Development of the <a href="#">Emergency Medical Teams</a> (2015), register &amp; certification mechanism for global health emergency workforce</li> </ul>
<b>IHR (2005)</b>	<ul style="list-style-type: none"> <li>- Strengthening country-level IHR capacities/resilient health system</li> <li>- Improve implementation of the IHR, develop a draft 5-year global strategic plan</li> </ul>
<b>R&amp;D</b>	<ul style="list-style-type: none"> <li>- Publication of an <a href="#">R&amp;D Blueprint</a> (2016)</li> <li>- Cooperation (MoU) with the <a href="#">Coalition for Epidemic Preparedness Innovation (CEPI)</a>, a public-private partnership launched in 2017; CEPI received <a href="#">US\$ 620 million funding</a> (62%) as of December 2017</li> </ul>
<b>International financing</b>	<ul style="list-style-type: none"> <li>- Establishment of a <a href="#">Contingency Fund for Emergencies</a> (2015); WHO received US\$ 44,5 million funding for CFE (44,5%) as of December 2017</li> </ul>

#### PHM’s Comments

The Ebola crisis was a stark reminder that global capacity to prevent, detect and respond to epidemics, was worryingly weak. One of WHO’s key strategic priorities for the period 2019-2023, as outlined in the draft General Programme of Work (GPW) aims to “keep the world safe” by ensuring

that an additional one billion people are better protected from health emergencies. However, the WHO faces several challenges in its stated endeavor to strengthen public health preparedness. PHM urges the WHO and Member states to consider the implications of framing the issue of emergency preparedness as a 'Health Security' issue. Such framing brings into conflict the rights and interests of individual countries with the need for global solidarity. Such a notion could advance a position that more developed nations should prioritize protection of their citizens from being affected by outbreaks in poor countries, rather than act in a spirit of solidarity towards affected countries. The imprint of this approach is unfortunately evident in the proposal for (voluntary) external evaluations of core capacities (for epidemic preparedness). A solidarity based approach should seek to address upstream factors which prevent less developed countries from acquiring capacity for disease surveillance and epidemic preparedness. These factors relate to both financial and technical deficiencies.

While PHM welcomes the draft five year global strategic plan to improve public health preparedness and response (*EB142/10*), some concerns remain regarding the ability of the Plan to address the key underlying factors that led the Ebola outbreak. To work towards a world free of the risk of outbreaks, such as the Ebola outbreak in 2014, we advocate an emphasis in the following areas:

### **Invest in strong health system based on the principles of Comprehensive Primary Health Care**

The priority for countries with fragile or weak health systems is clearly to ensure Universal Health Care for all its citizens so that everyone has access to affordable *and* quality health services. To attain this goal countries need to have secured finances for expansion of healthcare facilities, have sufficient human resources for health and ensure access to essential medicines. Such a system needs to be largely driven through the expansion of public services, needs to be networked with functioning linkages with different levels of care, and needs a strong emphasis on the primary level of care. A strengthened health system, based on the above criteria, is best suited to both address the population's basic health needs and constitute the basis of any response to health emergencies.

PHM supports the effort to build synergies between UHC and public health preparedness, as advocated in the EB document. However it is necessary that care be exercised to ensure that the efforts to build public health preparedness capacities (for instance, laboratory diagnostic capacity, epidemiological surveillance system, emergency response capacities, etc.) are not disconnected from people's everyday concerns and needs. Preparedness capacities are a necessary components of a well-functioning health system, which must also include a system with capacity to provide comprehensive healthcare services that are universally accessible and affordable. This is critical to ensure "community engagement", "national ownership" and "consultation", three of the 12 guiding principles guiding WHO's work on the issue (*EB142/10*, Annex 1, §1). External financial and technical support for countries lacking resources and technical expertise to develop IHR (2005) core capacities are necessary and need attention. However such support should not be contingent on the development of capacity for emergency preparedness in LMICs with poorly developed health systems, without attention being paid to the development of comprehensive healthcare services.

## **Urgent Need to enhance financial contributions to WHO's health emergencies programme and the implementation of the IHRs (2005)**

PHM urges Member States, especially those with higher paying capacity to substantially increase their financial contributions to WHO's health emergencies programme. Despite the lessons drawn from the Ebola crisis, global response capacities are still underfunded. This is compounded by the WHO's ability to pledge untied funds for the programme given that 85% of WHO's funding is earmarked for programs that donors wish to support. We note for instance that WHO's Contingency Fund for Emergencies has received only 45% of its planned US\$ 100 million capitalization (EB142/8 §40), while earmarked pledges to WHO's appeals in funding for health emergencies covered 79% of the target (US\$ 848 million) (EB142/9 §6). It is unfortunate that donors (including several Member States) would rather cherry-pick initiatives that they wish to fund rather than contribute through untied funds.

It is a matter of concern that this funding asymmetry is reflected in the lack of targets as regards required external financial support, in the WHO's plan to strengthen preparedness through the implementation of IHR (2005) core capacities. The only indicator suggested in relation to this critical work is the *"Number of countries supported annually in the development or updating of their national action plans for health emergency preparedness"* (EB142/10 Annex 3). Similarly, the draft strategic plan's 12 guiding principles include "domestic financing" but omits to mention obligations of Member States with better paying capacity to provide financial assistance for the development of preparedness core capacities (EB142/10 Annex 1, §1). It is unreasonable to, on one hand, exert pressure on developing countries to implement the IHR (2005) through the medium of the Joint External Evaluation (JEE), while on the other, abjuring the clear responsibility of High Income Countries to make financial commitments to support the implementation of IHR (2005).

## **Public-Private Partnerships for Global Health Security could undermine WHO's legitimacy and ability to effectively promote implementation of IHR (2005)**

The recent rise of public private partnerships (PPPs) directed at promoting global health security, such as the Global Health Security Agenda (GHSA) to strengthen the implementation of the IHR (2005) and the Coalition for Epidemic Preparedness Innovations (CEPI) to develop vaccines against infectious diseases with epidemic potential, needs to be scrutinized.

WHO plays a minor role in these public-private partnerships, thus providing the private sector with the opportunity to exercise considerable influence. These PPPs guarantee the industry 'win-win' outcomes: public subsidies cover their expenses; there is a potential for profit and reputational benefits. PHM notes for instance that WHO holds an observer seat on CEPI's board, whilst four seats are dedicated to the private sector and two to private philanthropic foundations. PHM underlines the necessity for the WHO to lead the work on emergency preparedness and urges Member States and the WHO to closely scrutinize the increasing role and influence of the private sector in this area.

## Issues in the Agenda of EB 142 related to Access to Medicines

*“Support the research and development of vaccines and medicines for the (...) diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines (...) to protect public health, and, in particular, provide access to medicines for all.”*

**Sustainable Development Goal 3b**

### Overall Recommendations by PHM

- We urge WHO member states to support the full adoption and funding of the recommendations of the overall programme review of the Global strategy and plan of action on public health, innovation and intellectual property (GSPOA). Many of the regulatory and transparency reforms are achievable without high-volume funding commitments.
- We urge WHO to set a clear date for publishing the “detailed implementation plan” to operationalize the recommendations of the overall programme review.
- We urge WHO to set a clear date for implementation for the refined recommendations of the overall programme review.
- We urge WHO to be visionary and active in establishing a global R&D convention that addresses the root-causes of so called “market failure”.
- We urge WHO and other international public health agencies to support bulk production of antivenom products locally by the public sector to increase its availability and affordability.

### PHM’s Analysis

#### 3.6 Addressing the global shortage of, and access to, medicines and vaccines

##### Background

This item was first discussed in January 2016 as “global shortages of medicines” suggesting a global approach to deal with supply side failure and market shaping.

##### **Report of the UN High Level Panel on Access to Medicines (UNHLP)**

In November 2015, the former UN Secretary General Ban Ki-Moon convened a panel of experts with the mandate to “review and assess proposals and recommend solutions for remedying the policy incoherence between the justifiable rights of inventors, international human rights law, trade rules and public health in the context of health technologies”. In September 2016, the UNHLP released its report, including recommendations to address the global challenges caused by high prices of medicines and lack of health needs-driven innovation. The report recognizes that (lack of) access to medicines is, now, a global issue.

In the lead up to EB140 in January 2017 the officers of the Board, however, elected not to include the UNHLP report on the EB agenda. This was controversial, since a many countries wanted to discuss the recommendations of the UNHLP report as a separate agenda item. During the adoption of the agenda the Board decided, as a compromise, to add reference to ‘access to medicines’ to the WHA70 agenda item on ‘shortages’. In May 2017 at WHA70, there was further sparring around the UNHLP report. The US led the opposition to consideration of the report supported by Japan.

Colombia, Brazil, India and others argued that there was much in that report for WHO to consider. It was decided to defer substantive consideration of Shortages and Access to EB142.

In preparing for the discussion at EB142, the DG has elected to step back and address the issues of shortages and access across a broad whole-of-supply-chain canvas as well as providing a brief interim report on the specific tasks arising from WHA69.25.

We commend the secretariat for mentioning the recommendations of the UNHLP in the report in Annex 3; however specific references to Intellectual Property (IP) related policies have not been included. Also, the issue of **delinking the cost of Research and Development (R&D) from the end prices of health technologies has not been addressed**; merely “a code of principles” has been mentioned as being “under consideration”.

It is of note that the current system relies on countries granting patent monopolies to pharmaceutical companies as the main way to incentivise innovation. This market-driven approach to R&D means that innovation mostly focuses on diseases affecting wealthy patients. However, diagnostics, vaccines and medicines are missing for many diseases affecting patients in both LMICs and HICs. The patent driven R&D system is clearly not delivering needed medicines. In the past 10 years only 25% of new medicines that received marketing approval provide an increased therapeutic benefit for patients over existing products (Revue Prescrire, 2015). The current crisis of antimicrobial resistance also highlights the inadequacy of the current R&D system.

#### ***Key-considerations and priorities***

In [EB142/13](#) a total of 33 ‘key considerations’ are drawn and on the basis of this list of ‘key considerations’ a series of possible actions for the Secretariat are identified in the report; actions for which a mandate already exists through previous resolutions. These are then prioritised in terms of impact, complexity and cost with three packages (in addition to work already underway - paragraphs 7 and 9):

1. high impact, low complexity and low cost (para 6);
2. high impact but more costly and more complex (para 8)
3. highly complex and expensive (para 10)

However, we believe a clear vision on access to medicines and vaccines should not exclusively discuss and harvest potentially low hanging fruits, but boldly implement strategies and approaches with the highest impact - and look at resources needed in a second step.

Moreover, we fail to understand some of the decisions made by the secretariat. For example paragraph 8 mentions “Develop(ing) policies that promote transparency throughout the value chain, including the public disclosure of clinical trial data, research and development costs, production costs, procurement prices and procedures, and supply chain markups.” involve “greater complexity and “additional resources”. PHM would like to submit that what is necessary while drafting a policy on transparency in R&D costs and clinical trial data is political will and WHO’s norm-setting capabilities, and not additional resources.

#### ***Definitions of stock-outs and shortages***

Clear technical definitions of shortages and stockouts and development of a global shortage notification system as requested in WHA 69.25 still needs to be addressed.

### 3.7 Global strategy and plan of action on public health, innovation and intellectual property (GSPOA)

We commend the secretariat for the comprehensive overall programme review of GSPOA:

The report of the evaluation of GSPOA presented at EB140 in 2016 was disappointing and did not provide any new valuable insights. Therefore, Member states collectively demanded a deeper, more pointed review. The presented overall programme review manages to clarify the underlying problems of the program:

1. WHO's funding crisis
2. 'vehement opposition' of the rich countries to a global fund for R&D

The underfunding is due to the fact that GSPoA is not funded by the core budget of WHO, but rather by tightly earmarked donations. This is an area where Member States and WHO need to collectively reflect as both evaluation and overall programme review appear to suggest that there has been virtually no progress in this area of work after almost a decade long investment of time and resources in a multitude of intergovernmental processes, dating back to the setting up of the open ended Intergovernmental Working Group (IGWG) in 2008. Moreover, the overall programme review identified the importance of TRIPS flexibilities and governments putting them into practise - this wasn't part of the original GSPOA.

To recall, the aim of the GSPOA, set out in paragraph 13, is to promote new thinking on innovation and access to medicines". After more than a decade of its existence, its original goals have been forgotten. The draft thirteenth General Programme of Work 2019-2023 completely fails to even mention the importance of TRIPS flexibilities and most importantly it doesn't mention the bold idea of an overarching R&D convention to safeguard public health and access to affordable medicines by delinking the cost of Research and Development from the price of a drug. The Overall programme review of the global strategy and plan of action on public health, innovation and intellectual property summarizes the decade long history on discussions on access to affordable medicines within WHO and describes a clear way forward.

- We therefore urge Member States to support the full adoption and funding of the recommendations of the review. Many of the regulatory and transparency reforms are achievable without huge funding commitments.
- We urge the WHO to set a clear date for publishing the "detailed implementation plan" to operationalize the recommendations of the overall programme review.
- We urge WHO to set a clear date for implementation for the refined recommendations of the overall programme review.
- We urge the WHO to be visionary and active in establishing a **global R&D convention** that addresses the root-causes of so called "market failure".

#### ***Fair price vs. affordable price***

With growing concern, we realize that in the past years the language around access to medicines has changed within WHO. Currently all documents on access to medicines mention a "fair price" where one would read "affordable price" before. This development can be seen in context of earlier

discussions on “too low prices” that made it unsustainable to produce a medicine. Therefore, the notion of a “fair price” that offers enough incentive to produce and market a drug evolved.

We need to ask ourselves what purpose WHO serves in the first place. If it was to balance profits of pharmaceutical manufacturers and the health of people around this planet, the “fair price” would be an appropriate term. However, the Constitution of WHO reads:

*The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition”*

This seems to underline WHO’s mandate to promote “affordable” not “fair” drug prices.

We urge WHO to change the narrative and language from “fair” drug prices for pharmaceutical manufacturers to “affordable” drug prices for the people.

#### **4.1 Global snakebite burden**

The inclusion of Global Snakebite burden on the agenda is encouraging, as it was long overdue. EB 142/17 clearly points out that “market failure has hindered investment in research and development, particularly in relation to improving current treatments and developing the next generation of biotherapeutics with the aim of reducing cost, improving safety and increasing effectiveness.”

In the past two decades, the prices of some antivenom products have dramatically increased, making treatment unaffordable. On the other hand, the dramatic increase in prices has further suppressed demand, owing to unaffordability, to the extent that antivenom availability has declined significantly or even disappeared in some areas.

However, antivenom products are merely the tip of the iceberg: The current situation is another symptom of a broken system of Research and Development that is centered around a market. Other examples include:

- Pandemics, such as Ebola: Despite Ebola was diagnosed since 1976, no vaccine was developed.
- Antimicrobial resistance and the development of new antibiotics: there have been only two new classes of antibiotics developed after 1962; AMR will kill an estimate 10 million people every year by 2050.

Antivenom products simply are part of the list of treatments for so called “neglected diseases” and they are one of the examples where “market failure” or the non-existence of paying customers leads to a lack of research and development and supply - even though about 125.000 people die per year due to snakebite.

- We therefore urge WHO to treat the underlying root-cause of the deadly snakebite burden and other so-called market failures by following the recommendation of the 2016 UN Secretary-General’s High-Level Panel on Access to Medicines and start serious negotiations for a Global R&D convention
- We urge WHO and other international public health agencies to support bulk production of antivenom products locally by the public sector, as it would increase its availability and affordability.



## **3.8: Preparation for the Third High-Level Meeting of the UN General Assembly on the Prevention and Control of NCDs, to be held in 2018**

### **Background**

This Policy Brief speaks to Agenda Item 3.8, ‘Preparation for the third High-level Meeting of the General Assembly on the Prevention and Control of Non-Communicable Diseases’, to be held in 2018. It argues that there is a “double speak” in the WHO’s approach to this topic. In some of its texts, it acknowledges that structural factors - particularly global trade and inequalities in power and resources within countries, between nation states, and between states and private corporations - underpin the growth of the NCDs epidemic. At the same time, its analysis also embraces the common wisdom that health is an instrument for socio-economic development, while WHO’s recommendations for stemming and managing the epidemic are apolitical and technocratic. Below we illustrate the disjunction between the political analysis of the causes of NCDs in EB142/15 and the technocratic recommendations set out in EB142/15 Add.1. We highlight underfunding of WHO anti-NCDs policies, along with the promotion of mHealth for tackling NCDs in the name of “cost-effectiveness”. We emphasize member-states ambivalence on supporting a strategy against NCDs that is critical of big business, and argue that the WHO has the authority and expertise to assist MS in developing a legally binding framework that regulates the influence of private sector actors on efforts to policies and programmes aimed at preventing the occurrence of NCDs.

### **PHM’s Analysis**

Agenda item 3.8 covers the Preparation for the third High-level Meeting of the General Assembly on the Prevention and Control of Non-Communicable Diseases, to be held in 2018 (EB 142/15), and preliminary evaluation of GCM (EB 142/15 Add.1).

EB 142/15 draws attention towards premature deaths occurring globally from non-communicable diseases owing to factors like poverty, and the impact of the globalization of marketing and trade of products deleterious to health. The increasing burden of NCDs in in low and lower middle income countries (LLMICs) is acknowledged in EB 142/15, and positions it as a potential impediment to development. The EB report particularly notes that within countries NCDs disproportionately affect the poor and the marginalised, thereby acknowledging the high burden of NCDs on the lives of poor people. EB 142/15 also notes that the progress towards fulfilling SDG target 3.4 on prevention of premature deaths due to NCDs has been insufficient as the number of premature deaths are declining at a slower rate than expected, especially LLMICs.

EB 142/15 further notes that member states’ investment in stemming NCDs is insufficient, particularly in LLMICs. The report lists various factors for these gaps at countries levels, which include:

- Political choices – weak political action at government level
- Health systems – LLMICs lack the required capacity to integrate the best buys and other recommended interventions for the prevention and control of NCDs
- National capacities – the supportive policy environment and technical expertise required for the prevention and control of NCDs is missing in most LLMICs

- International finance – there is lack of NCD projects to be proposed to international financing institutions for their consideration which forms a major impediment in mobilizing financial resources for NCDs initiatives
- Industry interference – multinational companies continue to interfere with member states' health policy making to suit their vested interests

In the context of these recognized barriers, the WHO secretariat has expressed its commitment towards providing support to countries in attaining SDG target 3.4. WHO identifies certain areas to provide its support, i.e. reducing tobacco use by 25%, reducing harmful alcohol use by 10%; keeping the levels stable for overweight; eliminating industrially produced trans-fatty acids; reducing prevalence of raised blood pressure by 20%; increasing service coverage for severe mental health disorders by 40%; and reducing mean population intake of salt by 40%.

### **NCDs: An additional Burden for the poor and marginalized**

PHM welcomes WHO's focus on this agenda item. NCDs are a growing public health concern worldwide, increasingly affecting the poor. The poor are most dependent on the public health system for managing these chronic conditions. Given the pool of risk factors in NCDs and existing gaps in the health systems response, it is also important to recognize the diverse effects they may have on lives of men and women given their gendered position due to the patriarchal power structure in society. Women are likely to experience NCDs differently than men given that they experience poor nutrition and barriers in access to healthcare services due to their lack of control over or access to economic resources, information, decision making and mobility. The experiences of societal stigma related to ill health of women may further impact their access to quality diagnosis, treatment and care. Also, the caregiving role is extremely gendered in most societies and invariably women assume the the role of caregivers in families and communities for those with NCDs, often in the long term and in the absence of provision of such services and care by health systems.

Health systems in low resource settings lack adequate preparedness to address NCDs. Since, most of the NCDs are chronic illnesses, the people suffering from these illnesses often require long term care, treatment and management. This would require a robust health system at various levels (primary, secondary and tertiary) with appropriate linkages and referral systems for diagnostics, treatment and care facilities. It is therefore crucial that health systems strengthening serve as the foundation of national NCD prevention and management programmes. Mapping of potential resources at the community level, i.e. going beyond health facilities, would be an important component of this as it ensures early screening for NCDs.

Like infectious diseases, NCDs are determined by socio-economic, nutritional and environmental factors. It is imperative to engage in further research on the social determination of NCDs amongst poor populations, particularly in LLMICs in order to formulate locally suited preventative strategies. Health systems in these countries would need support in developing large-scale interventions and programmes for NCDs, as there are few models to refer to given that health systems in LLMICs have historically focused on programmes for communicable diseases.

The double strategy of prevention and management has to be emphasised by member states in this context. While there has been some momentum in creating awareness towards prevention, for instance discussions around physical activity, dietary behavior etc., investing in better management of NCDs in low resource settings should form an essential component of any coherent national response to the epidemic.

### **Acknowledging Structural Inequalities as Fundamental Drivers of NCDs**

PHM welcomes WHO's acknowledgement that the burden of NCDs is rising disproportionately in LLMICs and that within countries the poor and marginalised are particularly affected. In particular, we welcome EB142/15's acknowledgement that the NCDs epidemic is underpinned by structural causes, and that behavioural factors have limited power in explaining the growing burden of NCDs amongst the poor. Significantly, EB142/15 argues that:

- “The global epidemic of premature deaths from NCDs is driven by poverty” and “the impact of the globalisation of marketing and trade of products deleterious to health”, amongst other factors (paragraph 2).
- LLMICs, because of their position in the global political economy, have “no capacity” to make “trade-offs” between pursuing trade-related SDGs, their broader economic interests, and reducing premature mortality from NCDs by one third by 2030 (Table 5, i, bullet 3). Conversely, “[h]igh-income countries show limited interest in reflecting the interconnectedness of promoting economic goals and promoting health in their international development cooperation as two sides of the same coin in terms of achieving the Sustainable Development Goals” (Table 5, v, bullet 4).
- “Despite commitments made in 2011, members of the OECD Development Assistance Committee have not prioritized the prevention and control of NCDs in bilateral development cooperation” (Table 5, iv, bullet 1).
- “Industry interference is one of the commercial determinants of health”, and “[m]ultinationals with vested interests routinely interfere with health policy-making, for instance by ...working to discredit proven science and bringing legal challenges to oppose progress” (Table 5, v, bullet 2). “Interference by industry impedes the implementation of ...recommended interventions, including raising taxation on tobacco, alcohol, and sugar-sweetened beverages” (Table 5, v, bullet 1). In “some instances, these efforts are actively supported by other countries, for instance through international trade disputes” (Table 5, v, bullet 2). The document does not specify which countries are guilty of this.
- Paragraph 5 of Annex 4 of the document states that “numerous challenges prevent the United Nations system from fulfilling its potential in supporting countries to NCDs. These inhibiting factors create a dissonance between country-level demands and the availability of resources and deployable assets from within the United Nations system”. It goes on to state that one such challenge is “[t]he influences of industry. Joint programming missions carried out by the Task Force [on the Prevention and Control of NCDs] have highlighted pervasive industry attempts to influence government policy. While the activities of the tobacco industry are well

established, the Task Force increasingly witnesses similar strategies from the alcohol, food and beverage industries, including industry briefing governments ahead of joint programming missions.”

Significantly, EB142/15 acknowledges that efforts to curtail the ability of “big food” to shape national nutrition interventions is a make or break issue for the WHO as some MS are fundamentally opposed to any interventions - even voluntary ones - designed to curb their influence. According to paragraph 16 “Member States have divergent political views on the extent to which the obstacles [listed above] impede progress towards target 3.4 and the political feasibility of the solutions proposed in paragraphs 13–15 [which focus on regulating and taxing health impeding industries, and great development assistance for SDG target 3.4]. If no consensus is forged on these issues during the first half of 2018, there is a risk that the consultations on the outcome document for the third High-level Meeting will default to a scenario that is the same as or worse than the current situation.”

### **Speaking in two voices: Significant Omissions and Disjuncture between analysis and Policy**

WHO recognises poverty, urbanization and global trade as factors responsible for the “global epidemic of premature deaths” from NCDs (p.1). It also suggests actions that take into account “the relationship between NCDs, poverty and social and economic development” (p.25). At the same time, it also views the premature mortality caused by NCDs as a threat to economic development. NCDs are thus simultaneously seen as a harmful consequence of growth-driven economic development, and as an impediment to achieving ever-higher levels of economic growth. The desirability and sustainability of the “high growth” model of economic development – particularly its globalized neoliberal variant – is never questioned, despite WHO’s acknowledgement that pursuing it is at the heart of the NCDs epidemic. We urge Member States to significant omissions in the EB document on: i) world trade agreements, ii) psycho-social factors of NCDs connected with working conditions, and iii) prioritization of “cost-effectiveness” over health and health promotion.

### **International Free Trade Agreements and “nutrition transition”**

In their current guise, trade liberalization agreements affect food availability in four ways<sup>1</sup>:

- a) Lowering trade barriers, increasing imports and thus leading to wider changes in trade policy.
- b) Affecting food availability and consumption through its effects on domestic production and food cultures in LLMICs.
- c) Expanding processed food markets (processed cheese, whey, French fries, snacks).

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<sup>1</sup> Ravuvu, Amerita et al. “Monitoring the Impact of Trade Agreements on National Food Environments: Trade Imports and Population Nutrition Risks in Fiji.” *Globalization and Health* 13 (2017): 33. *PMC*. Web. 19 Jan. 2018. Thow AM, Snowdon W: The effect of trade and trade policy on diet and health in the Pacific islands. In *Trade, Food, Diet and Health: Perspectives and Policy Options*. Edited by Hawkes C, Blouin C, Spencer H, Drager N, Dube L. Chichester, England: Blackwell Publications; 2010:147-168 - Hughes RG, Lawrence MA: Globalisation, food and health in Pacific Island countries. *Asia Pac J Clin Nutr* 2005, 14(4):298-306. Morley S: Trade liberalization under CAFTA: an analysis of the agreement with special reference to agriculture and smallholders in Central America, DSGD Discussion Paper No.33/MTID Discussion Paper No.95 Washington DC: International Food Policy Research Institute; 2006. European Public Health Alliance, *How CETA could undermine public health*, October 2016, p 6-7.

d) Establishing a two way relationship between food industry and countries: in negotiating, implementing and contesting trade agreements the food industry both responds to and shapes food and nutrition policies.

Tobacco, alcohol, processed food and uncontrolled white and red meat are strongly connected to NCDs. Nonetheless, as a result of the liberalization of trade they are imposed in the market as cheaper food options for consumers. The increasing availability and consumption of unhealthy foods is not a matter of lifestyle and choice, but an outcome of concrete socio-economic relations of power. The “*international trade obligations*” discourse, often used by US delegates (A70/B/PSR/4), has to be openly denounced as undermining public health.

### **Working conditions and unemployment**

Inactivity, which is strongly related to NCDs, is attributed, inter alia, to job strain (high demands/low control at the workplace). Unemployed people have significantly lower rates of leisure-time physical activity<sup>2</sup>. Psychosocial factors, such as low self-esteem<sup>3</sup>, also have a significant role on NCD prevalence. Unemployed people and workers in intense working conditions are disproportionately exposed to risk factors for NCDs (stress, etc), this reality is neglected in WHO’s recommendations.

### **The underfunding of anti-NCD policies and the ‘cost-effectiveness’ obsession**

According to WHO Budget Programmes, WHO funding for actions against NCDs has declined for the next biennium 2018-19 as the proposed budget for NCDs is 351.4 US\$ million compared to 376 US\$ million in 2016-17 [Table 1, Page 5, PB 2018-19]<sup>4</sup>. While EB142/15 admits that the decline of mortality is much steeper in High Income countries, a WHO study showed that scaling up a set of best buy intervention across all LLMICs would cost approximately US\$11.4 billion per year<sup>5</sup>. The same study reveals an obsession with “cost-effectiveness”, very problematic in the case of chronic diseases such as NCDs. This obsession seems to guide WHO’s mHealth strategy, which is mainly deployed in NCDs, in collaboration with ITU (a PPP). It seems, thus, that a crucial public health field has been left to the benevolence of

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<sup>2</sup> Sadiq Mohammad Ali, Martin Lindström, Psychosocial work conditions, unemployment, and leisure-time physical activity: A population-based study, *Scandinavian Journal of Public Health*, Volume: 34 issue: 2, page(s): 209-216, Issue published: March 1, 2006

<sup>3</sup> Nieman P. Psychosocial aspects of physical activity. *Paediatrics & Child Health*. 2002;7(5):309-312.

<sup>4</sup> Programme Budget 2018-19. World Health Organisation. [Accessible at [http://www.who.int/about/finances-accountability/budget/PB2018-2019\\_en\\_web.pdf?ua=1](http://www.who.int/about/finances-accountability/budget/PB2018-2019_en_web.pdf?ua=1)]

<sup>5</sup> World Health Organization, *Scaling up action against noncommunicable diseases: how much will it cost?*, Geneva: World Health Organization; 2011.

## Key Recommendations

### Tackling NCDs means:

- Implementing interventions that prioritise poor and marginalized groups (e.g. women and indigenous peoples), who increasingly bear the burden of NCDs.
- Strengthening public health systems, which are the primary providers of health care, particularly chronic care, for the poor and marginalised.
- Prioritising the development of human resources for health: mHealth can serve as an important tool to tackle NCDs, but they cannot and should not be substitutes for trained and well paid community health workers, nurses, doctors, and nutritionists.
- Supporting national healthcare systems through progressive taxation and regulation of health impeding industries.
- Regulating trade: regulating health impeding industries means prioritising public health, not “hand-tying” development
- Tackling inequalities in the workplace and psychosocial stressors that impede health.
- Formulating health policies that are informed by growing evidence that economies focusing solely on economic growth lead to inequalities of income, status and wealth inequalities, destruction of local food cultures, ecological destruction, and are not a “magic bullet” solution to poverty, unemployment or under-employment.

## 4.6: Maternal, Infant and Young Child Nutrition

### Background

Agenda Item 4.6 focuses on **Maternal, Infant and Young Child Nutrition**. This item covers the **Comprehensive Implementation Plan on Maternal, Infant and Young Child Nutrition: Biennial Report (EB142/22)** and efforts aimed at **Safeguarding Against Possible Conflicts of Interest in Nutrition Programmes (EB142/23)**.

**EB142/22** reports on the progress that has been made in carrying out the Comprehensive Implementation Plan on Maternal, Infant and Young Child Nutrition, proposed to extend targets on maternal, infant and young child nutrition to 2030 in order to synchronise them with the SDGs, and proposes an additional four indicators that should be added to the Global Monitoring Framework on maternal, infant and young child nutrition. These four indicators are: (1) minimum dietary diversity; (2) antenatal iron supplementation; (3) availability of national-level provision of counselling services in public health and/or nutrition programmes; and (4) trained nutrition professional density.

The document also reports on progress in implementing the International Code of Marketing of Breast-Milk Substitutes and Guidance on Ending the Inappropriate Promotion of Foods for Infants and Young Children.

Paragraph 29 of EB142/22 invites the board to note the report, and to consider a draft decision that requests the board to “note the analysis on the extension to 2030 of the 2025 targets on maternal, infant and young child nutrition”, “approve the four remaining indicators of the Global Monitoring Framework on maternal, infant and young child nutrition, as set out in this report”, and “to invite Member States to consider the full list of indicators in their national nutrition monitoring frameworks and report in accordance with decision WHA68(14) (2015)”.

**EB142/23** on managing conflicts of interests in national nutrition programmes sets out a proposed approach for preventing and managing conflicts of interest in developing and implementing national nutritional programmes. It describes the processes that have been followed since 2012 in creating the tool, and gives an overview of the tool itself. The tool is mainly focused on assessing and managing conflicts of interest risks that arise during the policy-making and implementation process, and in ensuring that this process is transparent.

### PHM’s Analysis and Recommendations

PHM welcomes WHO’s ongoing efforts to protect and promote the right to food, especially for mothers, infants and young children. However, the documents tabled do not acknowledge or address the destructive impact of the current economic system, patriarchal gender relations, and promote technocratic approaches to political problems on food sovereignty.

## **Social determinants of nutrition and access to food**

An emphasis on indicators as the primary mechanism for assessing nutritional status of mothers, infants and young children provide a useful snapshot of the nutritional profile of these groups over time. However, indicators cannot substitute for a historically informed, political economy analysis of maternal, infant and young child nutrition of the kind presented in the 'Universal Declaration on the Eradication of Hunger and Malnutrition' (1974), for example. Creating a 'snapshot' of the nutritional profile of specified groups generates useful empirical data, but does not allow for a systemic understanding how and why this 'snapshot' is generated and has limited utility in addressing the structural drivers of malnutrition generally, and amongst women, infants and children in particular. **Indicators should be read against a comprehensive analysis of the relationship between nutrition and structural processes such as economic policies (particularly trade policies that undermine food sovereignty and protect the political and economic power of the food industry), patriarchal gender relations, the ecological crisis, and the militarisation of political conflicts.**

## **Nutritional needs of reproductive age women**

Most of the indicators focus on child nutrition, or the nutritional status of pregnant women. No indicators measure the nutritional status of the women after giving birth and during the 6 months she should be exclusively breastfeeding, and the additional 18 months she should ideally continue breastfeeding. **There is a need for indicators that measure the nutritional status of reproductive age women, particularly during pregnancy and breastfeeding.**

## **Nutritional needs of breastfeeding women**

Currently, the policies and indicators/the plan make no commitment to protecting, promoting, and fulfilling the right to food amongst breastfeeding women. Instead, some of the literature on breastfeeding emphasises that women can produce breast milk that meets the nutritional needs of infants even when their own nutritional needs are neglected, sometimes routinely so. **WHO has missed the opportunity to include new indicators that protect and promote the nutritional needs and food rights of breastfeeding women.**

## **Macroeconomic framing of breastfeeding acknowledges its economic dividends... but ignores the costs women incur by doing reproductive work such as breastfeeding**

In a 2017 report, *Nurturing the Health and Wealth of Nations: The Investment Case for Breastfeeding*, breastfeeding is framed as a low cost and extremely beneficial investment in public health. This framing has since been incorporated into other texts advocating for exclusive breastfeeding for the first 6 months of a child's life. This policy is advocated for on the basis of research findings indicating that breastfeeding contributes to lower rates of obesity in adulthood, and cognitive and sensory development in children. PHM supports interventions that enable women to breastfeed, should they decide to do so. However, the macroeconomic framing of breastfeeding is problematic for several reasons.



1. **A macroeconomic framing, which emphasises cost-effectiveness and high investment returns, stands in tension with a human rights based approach to breastfeeding.** The market logic of endorsing breastfeeding on the grounds that it contributes to economic growth emphasise the economic expediency of breastfeeding.
2. **The macroeconomic framing does not reflect the true costs of breastfeeding.**
3. None of the indicators track the time women spend breastfeeding, the activities they forfeit by breastfeeding and related care work (particularly during period when infants are exclusively breastfeed), or the labour protections and subsidies they benefit from while breastfeeding (e.g. fully paid maternity leave; breastfeeding, pumping, and breast milk storage facilities at work; and affordable and good quality childcare facilities at work, etc.). Other pro-breastfeeding initiatives are characterised by similar oversights. For example, the *Nurturing the Health and Wealth of Nations* report notes that its “financing analysis does not include the costs associated with ...[enacting] paid family leave and workplace policies to support mother to breastfeed as recommended” while also mentioning that “[a]ccess to maternity leave has been found to increase exclusive breastfeeding rates by 52 percent, and has even been linked to lower infant mortality in some countries”. In the absence of these protections, exclusive breastfeeding of infants up to six months, and co-feeding up to two years, places a huge burden on women, particularly poor women, informal sector workers, and food insecure families. **Governments and employers that benefit from women’s investment in breastfeeding must provide the economic, legal and political infrastructure that enables them to do so in a manner that protects their socioeconomic welfare and bodily integrity.**

### **Adults mediate children’s access to food, yet the crisis of malnutrition and food insecurity facing adults is largely ignored**

Like breastfeeding, eating is both natural and learned. Adults mediate children’s access to and use of food: they are responsible for producing, buying, preparing, storing, and selecting foods. Today, adults’ capacity to routinely secure nutritious food for their households is undermined by a global food system that is characterised by an abundance of low cost and low quality food, industrialised and monopolistic food production systems, women’s lack of access to farmland, the privatisation of seeds, food waste, the widespread use of pesticides and antibiotics, and the destruction of indigenous food production and consumption practices. Within the constraints of this system, decisions about nutrition cannot be reduced to a behavioural issue. This system profoundly impedes adults’ ability to model “healthy food choices”, thereby undermining children’s ability to learn and adopt nutritional practices that protect their health over their life course. These systemic problems with the global food system must be addressed.

### **Existing policies reinforce existing gender relations**

Existing initiatives that promote exclusive breastfeeding for the first six months of an infant’s life understandably (but inadequately) prioritise the needs of pregnant and breastfeeding women. However, these initiatives ignore the role of male parents in tending to the nutritional needs of infants

younger than six months. The policies do not specify how men are supposed to be involved in infant care and nutrition, particularly in the context of initiatives that eliminate bottle feeding. Men are encouraged to take up other care work in the household, e.g. burping infants, changing them, and cleaning the home. However, there are no indicators within this plan that monitor the extent to which men actually execute these tasks aimed at supporting breastfeeding, or the extent to which they benefit from labour policies that allow them to take time off from work for paternity leave. In the absence of effective interventions that create a fairer division of labour between men and women with respect to infant feeding and domestic work, breastfeeding policies risk reinforcing patriarchal gender relations.

### **Need to strengthen guidelines for preventing and managing conflicts of interest in drafting and implementing national nutrition programmes**

The draft approach contained in **EB142/23** recognises the legal authority of member states to make legally binding regulations for preventing and managing conflicts of interests in the drafting and implementation of national nutrition programmes. It also acknowledges that some member states, particularly in the Global South, require technical support in order to execute this mandate well. However, it doesn't adequately address the fact that states in the Global South don't necessarily have the political power or economic resources to prevent or "manage" conflicts of interests that arise from their relationships with transnational food corporations or states in the Global North. A legally binding global instrument, similar to the Framework Convention on Tobacco Control, would help to bolster member states' capacities to withstand pressures from states and corporations that promote unhealthy foods.

In addition, the draft document suffers from a lack of clarity about (1) how national authorities responsible for preventing and managing conflicts of interest should be constituted so as to ensure that they promote the public interest; (2) procedures that ensure risk assessments and actual or potential conflicts of interest are undertaken in a transparent and accountable manner; (3) procedures for archiving and widely sharing the information that is used to evaluate potential or actual conflicts of interest; and (4) procedures for ensuring that the public interest is prioritised in the drafting and implementation of national nutrition programmes, and that this is not compromised by an approach to consultation that gives equal or greater priority to entities that act in their private interest.