

## World Health Assembly 2015: What happened?

The People's Health Movement (PHM) was at the World Health Assembly (WHA) in May 2015 and took part in key discussions affecting people's health, these include:

- WHO Reform implementation (agenda item 11.1),
- Proposed budget 2016-2017 (agenda item 12.2),
- Non-State Actors (agenda item 11.2),
- Non-communicable diseases (agenda item 13.4),
- Air pollution (agenda item 14.6),
- Antimicrobial resistance (15.1),
- Ebola (16.1),
- Malaria (16.2),
- Global vaccine action plan (16.4),
- Emergency and essential surgical care (agenda item 17.1),
- International recruitment of health personnel (17.2),
- Substandard/ spurious/ falsely-labelled/ falsified/ counterfeit medical products (17.3),
- Expert Working Group on R&D (17.4),
- Global strategy on public health and intellectual property (17.5).

This note aims to give an overall idea of the key discussions and outcomes of this year's WHA to PHM's country circles and steering council.

### 1. WHO reform and Programme and budget matters

The discussion on **WHO Reform implementation** (agenda item 11.1) was quite short (less than an hour). The importance of role of WHO in coordinating response to health emergencies was stressed several times, including by Germany, UK and Canada. In its response to countries' interventions, the WHO secretariat shared that the WHO is creating a single program for health emergency which will include global health emergency workforce.

Norway proposed to revive the Global Policy Group (GPG) that had worked on the review of the roles and functions of the organisations, 2012 onwards. The GPG consisted of the Director-General (DG), Deputy Director-General and the 6 Regional Directors. This proposition was supported by several developed countries (Australia, Canada, UK). In her address, Chair of the Programme, Budget and Administration Committee (PBAC) Miss Tyson, had praised the work of the GPG. The exact role of this body was initially not clear, but later on USA stressed that GPG should be a consultative body that advises the DG in her decision-making role (and not a body that makes decisions in her place).

There was very little discussion about financing and financial sustainability of the organisation. Ethiopia stressed that flexibility of funds should be included in the reform process, referring to the rigidity of earmarked voluntary funds.

Most developing countries that spoke stressed the importance of strengthening the capacity and role of country offices, including Lebanon, Maldives, Mozambique on behalf of AFRO.

At the end of the discussion, the report of the secretariat was noted.

The discussion on the **Proposed budget 2016-2017** (agenda item 12.2) is important to note in the context of the discussion on WHO reform and especially its financing. The Secretariat had initially stated (in document WHA68/55) that the 8% increase in base budget was going to be partially funded through a 5% increase (or US\$ 47 million) in assessed contributions. This would have been significant as it would have meant a de facto lifting of the freeze on assessed (i.e. mandatory) contributions. However, at the start of the discussion, the Chair of the PBAC informed the Assembly that the DG had changed her mind and that the 8% increase would be fully funded through voluntary contributions (through the financing dialogue to take place in November 2015).

This was very broadly supported during the discussion. In their interventions, developed

countries emphasized the importance of WHO and the importance of alignment and coherence between the 3 levels of organisation (meaning more central command, less regional autonomy - the third level being the country offices). USA called for an increased 'investment' in WHO, solely through voluntary contributions and a broader base of donor that includes all stakeholders - clearly referring to the private sector and philanthropic foundations. Canada emphasized the importance of FENSA (framework of engagement with non-state actors) to involve the private sector.

The little support for an increase in assessed contributions came from Norway and Switzerland. Maldives mentioned that dependence on voluntary contributions is unsustainable, but did not make a point for an increase in assessed contributions. Russia made a point that countries should be able to choose if they want to contribute through assessed or voluntary contributions.

Most African, Asian and Latino American countries that spoke supported the proposal of 8% increase from voluntary contributions and Argentina explained that not all countries would be able to increase their assessed contributions.

Netherlands and Spain had initially spoken against an 8% increase in overall budget, but changed their position after the DG took the floor calling for countries to adopt the budget at this WHA.

The discussion on **Non-State Actors (NSAs)** (agenda item 11.2) was one of the most difficult, with the key contention being the draft Framework of Engagement With Non-State Actors (FENSA). On the first day itself, the item was shortly opened to create a drafting group, with Argentina as chair. The drafting group met until the last day of the WHA and the final outcome was a Resolution to continue the discussion until the WHA69, through an open ended intergovernmental process to meet before October 2015, based on progress at WHA68, and that would submit a finalised framework to WHA69.

After such a hard negotiation process, there was not much more discussion. With regard to the draft Framework, consensus was achieved in major parts of the text. However there is no agreement on crucial issues such as the definition of resources, secondments, the relation of WHO with industries other than the tobacco and arms industry, transparency requirements, oversight mechanism of engagements with NSAs, ceiling on financial resources, etc. (For more details on the background of the process, see TWN's article on the issue [here](#).)

PHM and MMI made a [statement on WHO's relationships with 'non-state actors'](#) stressing that the WHO is being undermined in its capacity to promote global health; by underfunding, tight earmarking of donor funding and the opening of spaces for corporate influence.<sup>1</sup>

## 2. Health systems

The discussion on **Strengthening emergency and essential surgical care and anaesthesia as a component of universal health coverage** (agenda item 17.1) was mainly a debate on the provision of emergency and essential surgical care in primary health care settings (raised by Democratic Republic of Korea, Trinidad and Tobago, Thailand, among others) against more centralized model of provision through secondary and tertiary care settings in urban areas (Canada, most forcefully).

Some countries also promoted tele-medicine to solve access issues in rural areas, such as DRKorea, Thailand and Philippines, who have strong focus on trade in services in their economies.

A few African countries raised the issue of the critical human resources gap as a challenge, especially in the context of health human resources migration to developed countries, i.e. brain drain. Ethiopia stressed that developed countries have a responsibility to address this brain drain at least through support of training institutions in developing countries. This was also raised by Zambia. The proposed resolution (EB136.R7) was adopted without amendments.

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1 All civil society statements at WHA68 can be found [here](#).

While there was scope for content discussion with regard to the **WHO Global Code of Practice on the International Recruitment of Health Personnel** (the Code) (agenda item 17.2), only few countries addressed the core issues, notably Iceland and Cuba. The Assembly discussed the draft decision that endorses the recommendation of the Expert advisory group, which reflect many issues raised by civil society groups with regard to the Code's relevance and efficacy.

Speaking on behalf of 6 Nordic countries, Iceland stressed that there is both a shortage and a mal-distribution of health workers. Iceland stressed that developing countries have issues to retain health workers and the situation is getting worse despite the fact that strengthening of health systems is dependent on having trained personnel in the system. Iceland demanded that the priority in filling the information gap should be given to countries with highest workers gap, in a reference to the fact that sending countries are not providing the information sought under the Code with regard to health workforce migration.

Cuba reminded that the Code mentions the responsibility of the host country and encourage them to look into possibility of compensation. In this regards, Cuba requested the Secretariat for information if any country has contributed to training of health personnel in source country.

Cuba and Iceland stressed that while the relevance of the Code is clear, more evidence is required to assess its effectiveness. The Code is a voluntary instrument which has led several quarters to question its effectiveness.

Cuba also highlighted the existence of agreements between source and origin countries on health workers migration and requested the secretariat to give information on the number and content of such agreements.

Iceland also recommended that the Code become part of an overall human resource strategy, in the context of the mandate of the WHO to develop a Health Human Resource strategy for the WHA69 in May 2016.

The proposed Draft decision given in A68/B/CONF./3 was accepted without major amendments.

The discussion on **substandard/spurious/falsely-labelled/falsified/counterfeit medical products (SSFFCMPs)** (agenda item 17.3) was quite short and uncontroversial as the assembly only had to approve the Decision taken at the EB136 to endorse the report of the third meeting of the Member States Mechanism (MSM) on SSFFCMPs. However, few countries, such as India, used this opportunity to raise some fundamental questions.

During the discussion, India reminded that MSM is a process led by countries to deal with public health issues related with medicines and that its mandate excludes trademark consideration, stressing the danger of confusing both issues. India stressed that this danger is increased by the fact that there is no common definition of SSFFC and that such a definition is needed to advance the work of the MSM. Philippines also asked for a clear definition of SSFFC.

The third MSM meeting had reviewed recommendations for health authorities to detect and deal with actions, activities and behaviours that result in SSFFC, as well as on the identification of activities and behaviours that fall outside the mandate of the MSM. While the list of activities that result in SSFFC was approved, the list of activities that fall outside the mandate of the MSM could not be agreed upon. One of the activities listed is the seizure of in-transit medicines. During the discussion, India expressed its concern that some countries assume that seizures in-transit are an acceptable practice. India further noted that exclusive emphasis on regulation alone cannot provide a solution. This was echoed by Brazil that criticized the enforcement approach and seizures of shipment of drugs. There was not much responses to these issues, though Spain spoke of the importance of prosecuting SSFFC.

[PHM and MMI made a statement](#) calling on MS to leave aside commercial considerations and focus on issues of public health. PHM and MMI stressed that in transit seizures of medicines should be clearly listed to fall outside the mandate of the MSM.

The EB136 Decision also proposes that the review of the MSM planned for 2016 be postponed to 2017. This was accepted.

The discussion on the **Follow-up of the report of the Consultative Expert Working Group on Research and Development: Financing and Coordination (CEWG)** (agenda item 17.4) was short as well. The Assembly only had to note the report on progress made on the implementation of chosen research projects, as well as consider the proposal for a pooled fund for research and development as a follow up of the CEWG report of 2012 (A68/34). Perspectives on the pool fund dominated most of the discussion.

A key element was the sustainability of the fund as the proposal contained in the document is for a voluntary fund. While a few developing countries raised the issue of the sustainability of the fund (such as India and Morocco), a few other developing countries clearly stated their support for a voluntary fund, such as Turkey, Malaysia and Sudan. The EU stressed on a voluntary fund but through the WHO budget and Canada made its support conditional to the fund being voluntary and managed by the UNICEF/ UNDP/ World Bank/ WHO Special Programme for Research and Training in Tropical Diseases (SPR TDR).

UNASUR (Union of South American Nations) raised the need to go back to discussions which had been 'suspended', probably alluding to the discussion on an R&D Treaty proposed in the CEWG Report, and asked the DG to convene an open ended working group to work on the issue. This was echoed by India. In 2013, the WHA had committed (WHA66.22) to convene an open-ended meeting of MS prior to WHA69, in May 2016, in order to assess progress and continue discussions on financing for health R&D taking into account the CEWG report recommendations. In its intervention, PHM and MMI stressed that the open-ended meeting of Member States is the appropriate place to discuss the proposals contained in the document A68/34 and reopen the discussion on an R&D Treaty. (Find the statement [here](#).)

The discussion on **Global strategy and plan of action on public health, innovation and intellectual property (GSPOA)** (agenda item 17.5) was to approve a EB136 decision relative to the review and evaluation process of the GSPOA. Bolivia tabled a Resolution proposing time-lines for both evaluation and review as well as modalities of the processes (A68/B/CONF./1).

While the review and evaluation constituted a major part of the discussion, some countries also took this opportunity to raise trade related issues. Mauritius raised that, despite their importance and compatibility with TRIPS, parallel importation of compulsory licensed products is not implemented. Mauritius also stressed that amendment of national legislation in order to be compliant with TRIPS is an issue for public health. Malaysia raised the impacts of intellectual property clauses in trade agreements and Indonesia stressed that the country's patent law enforcement, including issuing of compulsory licenses, is in line with public health concerns. India also declared its support for TRIPS flexibilities, such as compulsory licenses. In their intervention, [PHM and MMI](#) stressed that the space for TRIPS flexibilities has been progressively reduced through more stringent provisions than those under TRIPS (TRIPS +) that are pushed in bilateral and plurilateral trade agreements.

With regard to the evaluation China stressed it should be carried out by external evaluators to avoid conflict of interest and enhance transparency in the process. USA opposed the proposition that MS would select the evaluators since it 'politicises' a 'technical' process. Brazil responded by emphasizing the importance of greater involvement of MS in both evaluation and review. Australia responded back by stressing that to be in-line with WHO evaluation policy, the evaluation of a technical group should have minimum participation of MS. As there was disagreement over this element of the Resolution, informal consultations were held. As a result, the Resolution was amended so that the role of MS in appointing the Evaluation Management Group as well as the 18 experts on the review panels is decreased.

### **3. Communicable disease and Preparedness, surveillance and response**

The discussion on **Malaria: draft global technical strategy** (agenda item 16.2) focused on the text of the resolution contained in document EB136/R1. Thailand proposed two amendments that highlight the role of PHC as the main platform in comprehensive cross border malaria control and the importance of integration of this model into the broader health care delivery systems, as well as integration of donor supported programmes into national health systems to achieve long term programmatic and financial stability. However, USA questioned the 'phrasing and intention' or raising financial stability. The Resolution went back to the drawing board and Thailand presented it again a few days later, without the language related

to donors and financial stability.

The discussion on 2014 **Ebola virus disease outbreak** and follow-up to the Special Session of the Executive Board on Ebola (agenda item 16.1) had several documents to discuss:

- A68/25: Progress report of the Ebola Interim Assessment Panel
- A68/23 (WHO response in large-scale emergencies)
- A68/24 (2014 Ebola virus disease outbreak)
- A68/26 (contingency fund)
- A68/27 (emergency workforce)
- A68/51 (draft decision)

Document A68/25 was discussed first, through a presentation by the chair of the Panel. The central point of the Panel was defining a mandate for WHO in situations of emergency. The Panel looked at International Health Regulations (IHR), the development of WHO as emergency agency and the development of a worldwide humanitarian system. In general, there was a large support for WHO's central role in emergency situations. Germany spoke to WHO's new relevance. Also raised as an issue was the need to also look at health system strengthening. Japan suggested that resilient health systems should be built in the context of IHR. The African Region statement, read by South Africa, focused on the importance to rebuild health systems but did not address it in depth. Margaret Stocking concluded the discussion on behalf of the WHO Secretariat by saying that the Secretariat had spent considerable effort in developing ideas regarding reform of WHO, to become the emergency agency, and this is being taken forward now.

Documents A68/23 (linked to EBSS3.R1), A68/24, A68/26 and A68/27 were taken together. Both the contingency fund and the creation of an emergency workforce team were welcomed.

The issue of sustainability of the fund was raised. Egypt suggested that a mechanism for fund replenishment should be proposed. There was no clear proposition for mandatory contributions to the fund. Canada stressed that it should be voluntary and with participation of the private sector.

Egypt also raised that the scope and accountability mechanisms for the fund needed to be discussed. But developed countries were more concerned that the funds need to be 'disbursable quickly' (Germany). USA articulated the core of this discussion, which is that WHO needs to be able to release funds before an outbreak in order to ensure that emergencies do not become an international crisis. In line with this idea, the funds will be used for first phase emergency response and for a maximum of 3 months. This does not leave space for long term rehabilitation plans, and health system strengthening to be covered by this fund. In their intervention, PHM and MMI reminded the Assembly that if this Ebola outbreak does not trigger substantial investments in building resilient health systems, then pre-existing deficiencies in health systems will be exacerbated. The World Bank (WB) also took the floor and spoke of the emergency financing facility it is developing and that WB and WHO are going to be discussing pandemic financing together.

With regard to the emergency health workforce, the EU stressed that the trigger mechanism for the deployment of this force needs to be defined. Norway proposed that the decisions should be directly under the DG.

USA stressed that while WHO should play a role in R&D in case of health emergencies it was not happy for the WHO to be an investigator in clinical trials. The secretariat defended the role of WHO as 'trial sponsor of last resort'. PHM and MMI stressed that the prevailing model of profit-driven research & development neglected Ebola ever since the isolation of the virus in 1976, calling for an alternate model which delinks research and development from profit expectations, and makes treatments more affordable and accessible. (See PHM and MMI statement [here](#).)

With regard to the Draft Decision (A68/51), a drafting group was created, and a resolution - based on the Draft Decision (A68/A/Conf/5) - was approved without amendments.

The discussion on **Global Vaccine Action Plan** (agenda item 16.4) was one of the most contentious of this WHA. Libya had tabled a very good resolution to promote access to

vaccines, including importance of generic local manufacturing capacity and pooled regional procurement as well as raising that intellectual property is a barrier to affordable prices of vaccines (A68/A/CONF./4).

In the first of a series of discussions on the Resolution, the text received wide support. Japan asked if intellectual property protection is really a problem for accessing vaccines and requested that the mention of an "IP barrier" be deleted from the text. USA requested for time to consult with 'the capital' and the EU could not pronounce itself at that point (Wednesday late afternoon). Thailand proposed a series of amendments (that had been discussed with India and Brazil among others).

On Saturday morning, the Resolution was brought back to the Assembly but opposed by USA and Canada that asked for the discussion to be postponed to the EB137 on the ground that procedural 'best practices' should be followed regarding this resolution - these countries had been complaining that the Resolution was tabled too late and was not discussed in the EB before being brought to the WHA. However, there is no rule that such procedures should be followed, which is why the request was for procedural 'best practices' to be followed.

Latvia requested further amendments, especially the dilution of the language regarding government's publication of company prices to allow governments to respect commercial secrecy agreements signed with manufacturers. Thailand opposed the amendment proposed by Latvia and requested the inclusion of the original language regarding intellectual property barriers. Several developing countries expressed their support for this language to be brought back into the text. PHM and MMI did so too, also stressing omissions in the proposed text (see PHM and MMI statement [here](#).) Japan opposed the language proposed by Thailand but supported the revised resolution.

A large majority of developing countries stressed the need to ensure affordability and accessibility of vaccines, and emphasized the importance of price transparency. Argentina stressed that the resolution is a tool against unacceptable practices by large manufacturers that use their monopoly situation to put pressure on countries, even to the extent of interrupting immunization programs.

In the face of such strong support for the resolution, Australia proposed that an informal drafting group be formed to find acceptable language for all. Switzerland raised procedural issues, but agreed to an informal consultation. The informal consultation reached an agreement and the somewhat diluted but still meaningful Resolution was adopted on Monday. (For a detailed account of the discussions and changes made in the text, please see TWN article [here](#).)

As part of the **Antimicrobial resistance** (AMR) agenda point (item 15.1) the Assembly discussed the Global Action Plan on Antimicrobial Resistance (GAP, A68/20) as well as a Resolution that contains a concrete work program for a surveillance and monitoring mechanism (A68/A/CONF./1). Developing countries felt that the resolution did not address key concerns, especially in relation to access to existing and new anti-microbial agents and diagnostic kits as well as financial and technological resources to develop and implement national action plans in line with the Global Plan. India stressed that AMR is a developmental challenge and not only a health security issue, underscoring both access and required financial support. The statement from Ghana on behalf of the African Region stressed the same issues.

After informal discussions, several amendments were included on those lines, including tracking of resource flows for R&D on AMR in a new global R&D observatory. Further, the framework clearly includes the promotion of affordable access to new and existing antimicrobial medicines and diagnostic tools. (For a detailed analysis of the changes made in the text, see TWN article [here](#).) The report was noted and the Resolution adopted.

#### **4. Noncommunicable diseases and Promoting health through the life course**

The discussion on **Air Pollution** (agenda item 14.6) was opened on Thursday morning and directly sent into a working group to reach consensus on a Resolution. This is another discussion that required a sustained series of closed group sessions.

During the discussion, countries recognised air pollution as major cause of morbidity and mortality worldwide, including indoor pollution. Few countries mentioned the need to promote the use of new technologies and the importance of developed countries support for developing countries' use, such as India, DRC Congo. Switzerland and Uruguay made a point to note that sources of pollution are not explicitly stated in the text, without demanding that it be included. This had been discussed and settled in the drafting group as several countries had wanted to pin-down main emitters such as China and other emerging economies (probably India too). PHM and MMI emphasised the threats to policy space to set norms and standards on the issue due to investment and intellectual property provisions in trade agreements (see statement [here](#)).

The Resolution was approved as presented after a week-long series of drafting group meetings.

The outcome of the discussion on the **Follow-up to the 2014 high-level meeting of the United Nations General Assembly to undertake a comprehensive review and assessment of the progress achieved in the prevention and control of noncommunicable diseases (NCDs)** (agenda item 13.4) was to note a report earlier discussed at the EB. The discussion did not take much time. An element of interest was Nordic countries (such as Finland and Norway) raising that there is unprecedented amount of corporate interest in NCDs, and linking this with the high importance of an effective framework for engagement with NSAs (FENSA). Finland stated that WHO need to engage with NSA while protecting its decision making functions. This was also supported by Thailand. PHM and MMI stressed that the burden of high level meetings and endless indicators are diverting the attention from the real priorities and called on the WHO to pay more attention to the influence of trade and investment agreements on the spread of noncommunicable diseases (see statement [here](#).)

Prior to the Assembly, PHM prepared a comprehensive [commentary](#) on the documents presented for discussion. In addition, the comprehensive notes of the discussions that took place at the assembly are also available here (as a comprehensive document) and [here](#) (categorised by agenda items along with our commentary on each specific item). These documents, the statements prepared for the Assembly as well as all more materials prepared by the WHA68 Watchers team can be found [here](#).