

People's Health Movement

Background and Commentary on Items before EB146 February 2020

This analysis and commentary on items coming before the WHO Executive Board in Jan 2020 has been prepared by the [People's Health Movement](#) as a contribution to WHO Watch, a civil society initiative directed to the democratisation of global health governance ([more about WHO Watch](#)).

This Commentary is produced through PHM's team of policy analysts in consultation with a global network of consultants.

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6. Primary Health Care	3
7.1 Universal health coverage: moving together to build a healthier world	6
7.2 Political declaration of 3rd HLM of UNGA on NCDs	11
8. Global Vaccine Action Plan	19
9. Accelerating the elimination of cervical cancer as a global public health problem	26
10. Ending TB	30
11. Epilepsy.....	37
12. Integrated, people-centred eye care, including preventable blindness and impaired vision.	40
13. Neglected tropical diseases.....	43
14. Global strategy and plan of action on public health, innovation and intellectual property	46
15.1 The Independent Oversight and Advisory Committee for the WHO Health Emergencies Programme	55
15.2 WHO's work in health emergencies	58
15.3 Influenza Preparedness.....	62
15.4 The public health implications of implementation of the Nagoya Protocol.....	65
15.5 Cholera prevention and control	72

17. Decade of Healthy Ageing.....	76
18. Maternal, infant and young child nutrition	81
19. Accelerating efforts on food safety	88
20. Data and Innovation: Global Strategy on Digital Health	91
21.2 Financing and implementation of the Programme budget 2018–2019 and outlook on financing of the Programme budget 2020–2021	96
22.1 WHO Reform	97
22.2 Engagement with non-State actors	100
23.1 Evaluation: update and proposed workplan for 2020–2021	103
25.5 Human resources: update	106

6. Primary Health Care

In focus

Responding to the request in resolution [WHA72.2](#) (2019) on primary health care, [EB146/5](#) conveys a draft operational framework for primary health care. The report outlines the levers of the draft operational framework that are essential to strengthening primary health care implementation towards universal health coverage at country level.

The Board will be invited to note the report.

In [WHA72.2](#) the Assembly endorsed the Astana Declaration and requested the DG to develop an Operational Framework for PHC in time for consideration at WHA73 (May 2020) to scale up health systems and implementation of PHC.

See [PHM Updater on this resolution from WHA72](#).

See also related Item 7.1 on UHC which set out 'next steps' with respect to UHC, including the proposed Special Programme on Primary Health Care, which is contingent on the 'operational framework' proposed in [EB146/5](#) being approved. See [PHM comment](#) on that item.

See also related Item 23.1 Review of 40 years of primary health care implementation at country level ([EB146/38 Add.1](#)). Also see [PHM comment](#) on that item.

Background

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

In particular see [PHM Comment on EB144 Item 5.5 on UHC](#) which provides links to a range of useful papers produced by WHO and UNICEF in advance of the Astana Conference in 2018.

PHM Comment

The People's Health Movement (PHM) has welcomed WHO's renewed commitment to PHC but has been critical of its agnostic approach to health care financing (single payer versus health insurance markets); its optimism regarding the role of the private sector in service delivery; and the omission of mention of health risks which arise from neoliberal globalised capitalism.

The articulation of PHC in the DG's Report goes further than the Astana Declaration and PHM welcomes this. Para 2 defines the primary health care approach quite comprehensively, incorporating the main elements of the approach, including multi-sectoral approach, community empowerment and integrated health services.

The draft operational framework provides 14 levers for operationalisation of primary health care- four core strategic levers and ten operational levers.

Within the strategic levers, governance and policy frameworks need to explicitly include regulation of the private health sector, industries and their markets, action on commercial determinants of health and promotion of fair trade. In relation to funding and allocation of resources too, it needs to be acknowledged that governments, especially in LMICs, cannot have fiscal space unless there is an international economic order that promotes fair trade and policies. Moreover, funding systems needs to be developed as an integrated single payer publicly funded system and resource allocation needs to be equitable.

The operational levers need to aim to attain a health system based on social solidarity and built on a unified public funded system, with most service provision through public institutions. The models of care need to take into account equity, and this needs to be made explicit (see [WHO \(2014\) Equity and UHC](#)). See [PHM comment on Item 7.1 on UHC](#) for further comment on health care financing and service delivery.

Empowerment of the community should be added as an operational lever, in which acceptability and responsiveness of services, grievance redressal systems and systems for planning, review and monitoring by the community need to be included. Further, participation of the poorest, women, vulnerable groups, and so on, need to be ensured.

The proposed partnership with private-sector providers for 'delivery of integrated services' is very optimistic and belies global evidence. Globally countries that have depended on the private sector instead of the public sector, for delivery of public health and other public services, have faced huge challenges in ensuring access, financial protection and equity. Therefore the emphasis within the draft framework should be instead on developing and strengthening the public health system to deliver health care services. The engagement with the private sector providers should be in terms of their regulation, such as price control, and accountability, such as grievance redressal and protection of patient's rights.

Within 'purchasing and payment systems' it needs to be emphasised that a single payer public system with public provisioning is the preferred service delivery model. Further, there needs to be mention of reduction in catastrophic expenditure and preventing out of pocket expenditure on health as primary goals, as included in SDG indicator 3.8.2.

Diagnostic services are extremely important as seen from the [WHO's Essential Diagnostics List](#), however it is currently missing in the framework. It therefore needs to be added to the lever on 'Medicines and other health products to improve health'. It needs to be ensured that digital and other technology is used with intelligence, after assessing it's potential to do harm as well as good and its contribution to overall population health and equity. The use of digital technologies must be informed by an awareness of the digital gradient, which mirrors socio-economic inequities. Special measures need to be taken to flatten this gradient and regulate technologies as required.

Research on primary health care needs to be embedded within local knowledge systems and with the community as an equal participant. Emphasis needs to be on indigenous and national and sub-national institutions and researchers. It needs to be acknowledged that countries are

not starting with a clean slate. Certain countries have already progressed on operationalising PHC and their experiences and lessons need to be documented. In relation to monitoring and evaluation, healthcare providers should not be overburdened with data gathering and collation and only relevant and useful data needs to be collected. Policies on ownership and privacy of patient data need to be developed. Most importantly, the community (including local governance systems, elected representatives) and patients should not be relegated to just being sources of data harvesting. They need to be acknowledged as active participants in monitoring and evaluation of PHC programmes and systems developed to ensure their participation.

Para 13 talks about how the actions and interventions need to finally guarantee “overall results along the three dimensions of universal health coverage”. However, without equity considerations, any action on the three dimensions would not lead to the main objective. In fact it could derail any progress, as evidenced in many countries. Therefore ‘equity’ needs to be explicitly mentioned in this paragraph.

In engaging “stakeholders” to “define health needs, identify solutions and prioritize action”, care needs to be taken with regards to involving the private sector and industry as they may try to further private rather than public interests. The experience in many countries has shown that while not-for-profit private organisations that work for vulnerable populations can be brought on board to advocate for public interest, it is nearly impossible to mitigate conflicts of interest in relationships with the for-profit private sector. Therefore they should not have a place at the policy table.

PHM urges the EB to ask for revision of the problematic content and inclusion of the above omissions in the draft operational framework will be submitted for consideration by the Seventy-third World Health Assembly in 2020.

PHM notes the proposal in [EB146/6](#) (to be considered under Item 7.1) for a Special Programme on Primary Health Care. EB146/6 (para 14) explains that the Special Programme

is being created as a “one-stop” mechanism for providing implementation support to Member States. It will put into action the operational framework for primary health care, once it is approved, which outlines 14 levers around which countries and partners may want to prioritize their investments and customize their actions to accelerate progress across all three components of primary health care: (a) multisectoral policy and action; (b) empowering people and communities; and (c) putting primary care and essential public health functions at the core of integrated health services.

Establishment of the Special Programme is conditional upon the approval of the Operational Framework.

7.1 Universal health coverage: moving together to build a healthier world

In focus

[EB146/6](#) recalls the Political Declaration of the HLM of the UNGA on UHC in September 2019. (See <https://www.un.org/pga/73/event/universal-health-coverage/> for the Political Declaration and various other documents.)

In [EB146/6](#) the DG emphasises the central importance of primary health care ‘on the road to universal health coverage’; reviews the highlights, achievements and challenges identified by [WHO’s 2019 monitoring report](#); and affirms the fact that investment in primary health care is an effective, efficient and equitable way to advance universal health coverage and eliminate catastrophic health expenditure.

The report also describes the next steps for WHO, including provision of support for the strengthening of health systems, multisectoral approaches through primary health care, and sustaining progress towards universal health coverage.

The report makes several references to the [Global Action Plan \(2019\)](#) adopted by 12 multilateral agencies including WHO and directed to accelerating country progress on the health-related Sustainable Development Goals (referred to below as GAP 2019)

The Board is invited to note the EB146/6.

Note that the ‘next steps’ set out in this report, in particular the creation of a Special Program on Primary Health Care, are contingent on the governing bodies’ approval of the proposed Operational Framework for PHC development to be considered under Item 6 on primary health care and informed by [EB146/5](#).

Background

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

PHM Comment

Shortfalls in UHC goals and targets

EB146/6 lays out clearly the shortfalls with respect to the SDG goals and targets relating to UHC.

The [monitoring report](#) shows wide variations in service coverage, and increasing health care impoverishment and catastrophic expenditure. Other indicators show the continuing heavy burden of infant and maternal deaths and low levels of vaccination.

A series of graphics in the GAP 2019 report ([pp2-4](#)) depict the shortfalls very clearly in relation to SDG 3.8 (UHC).

Unfortunately, EB146/6 does not offer any explanation for the increase in catastrophic health expenditure between 2000 and 2015.

PHM believes rising health care impoverishment (despite the promises of the SDGs) reflects widespread underemployment (with stagnant wages), fiscal austerity (and privatisation), and widening economic inequality (and deepening poverty). These in turn reflect imbalances in the global economy associated with neoliberal policies and economic globalisation.

Although EB146/6 mentions access to medicines and diagnostics there are no references to trade agreements (multilateral and bilateral) which incorporate TRIPS Plus provisions and investor protection provisions, both of which contribute to maintaining the high prices of medicines.

PHM calls on public interest civil society organisations and networks globally and nationally to promote a wider understanding of the underlying causes of the shortfalls in the promises of UHC.

Appreciation of the Special Program on PHC

PHM welcomes the proposed Special Program on PHC described in paras 13-16 of EB146/6. We note that the creation of the program is conditional on governing body approval of the proposed Operational Framework for Primary Health Care (presented to the Board under Item 6 and introduced in [EB146/5](#)).

PHM supports the adoption of the Operational Framework and the creation of the proposed Special Program.

Appreciate the endorsement of PHC by the 12 agencies in the GAP

PHM appreciates the endorsement of 'country led primary health care' by the 12 agencies involved in the [Global Action Plan 2019](#), and the recognition, by the 12 agencies, of PHC as one of seven 'accelerators' for achieving progress on the health-related SDG targets.

We appreciate the repeated references to PHC in the GAP, including: "A strong primary health care system is the most effective vehicle for delivering essential health services and is a cornerstone for achievement of the health-related SDG targets and enabling progress on other accelerator themes." See in particular [GAP 2019 page 52](#) on PHC.

See Box 12 (page 41) which includes, among 'proposed joint actions on primary health care (global/regional-level actions)' ... "Ensure more coherent, effective support to countries by aligning approaches and tools and promoting action on public goods in the following areas: 1 Collaborate on the three components of primary health care using existing mechanisms, including reframing financial support, where appropriate".

See also support for community and civil society engagement from page 45 and action on the commercial determinants from page 46.

Different interpretations of PHC

PHM particularly appreciates the affirmation in EB146/6 of the definition of PHC offered by WHO in the lead up to the Astana Conference, namely (as included in [EB144/12](#)):

11. Primary health care is a whole-of-society approach to health that aims to ensure the highest possible level of health and well-being and equitable distribution through action on three levels:

- meeting people's health needs through comprehensive and integrated health services (promotive, protective, preventive, curative, rehabilitative and palliative) throughout the life course, prioritizing primary care and essential public health functions;*
- systematically addressing the broader determinants of health (including social, economic and environmental factors, as well as individual characteristics and behaviour) through evidence-informed policies and actions across all sectors;*
- empowering individuals, families and communities to optimize their health as advocates for policies that promote and protect health and well-being, as co-developers of health and social services and as self-carers and caregivers.*

This is the definition included in the Operational Framework and will guide the Special Programme if it is approved.

However, it appears that there is still some confusion (or perhaps contestation) within WHO about what PHC is. In the footnote on page 1 of EB146/6 the reader is referred to para 29 of A71/4 which returns to the construction of PHC as simply 'primary care'.

PHM urges the Secretariat to replace this reference with a reference to EB144/12, para 11, quoted above, before forwarding this document to the Assembly.

Appreciate emphasis on accountability

There are several references to the many commitments made by member states in adopting the UN Political Declaration, "Universal health coverage: moving together to build a healthier world" ([UNGA 74/2](#), 10 Oct 2019).

Clearly the DG will be seeking to gain maximum leverage from these commitments.

PHM appreciates the emphasis on accountability in EB146/6, including the reference to the United Nations Secretary-General's [Independent Accountability Panel \(IAP\)](#) for Every Woman, Every Child, Every Adolescent.

However, donors must also be accountable

PHM appreciates also the commitment to accountability of the 12 agencies which are party to the GAP 2019.

However, the donors must also be accountable.

On page 5 of the GAP 2019 the 12 agencies call for better targeted financial assistance to assist poorer countries to move more swiftly to the UHC targets. The report notes that:

“To be avoided are approaches to health financing that may bring in additional resources but that further fragment systems and become obstacles to UHC rather than enablers.” (... And add to countries’ transaction costs” could be added to this.)

There is nothing in the GAP to indicate how the donors will achieve this (like so many broken undertakings in the past), nor how they will be accountable for it.

UHC is a slogan which obscures important policy differences

The apparent consensus of the 12 agencies behind the GAP 2019 obscures important policy debates over models of service delivery and health care financing.

Agreeing to obscure important policy debates is the price that WHO has paid for the support of the 12 agencies, powerful philanthropies and big bilateral donors.

Public sector service delivery

PHM appreciates the support for primary health care, people-centred approaches and investments in strengthening health systems. However, EB146/6 manages to avoid completely the choices between health service delivery through a strong public health system versus mixed service delivery with a strong private sector.

Public sector provision gives policy makers significant power over efficiency, effectiveness, quality and equity. Importantly this applies at the provider level and at the wider network and program level. The main risks associated with public sector provision arise from under-funding.

Private sector service delivery insulates providers from policy control over equity (eg distribution of resources), efficiency (eg preventing over servicing) and quality (eg rational use of medicines). The degree to which equity, efficiency and quality are sacrificed for profit depends on the effectiveness of regulation and effective regulation of private sector providers is difficult and expensive.

Tax based health care financing rather than health insurance

Both EB146/6 and the GAP 2019 report are silent with respect to health care financing: tax based financing versus health insurance.

Tax based, single payer systems provide policy makers with powerful levers to promote efficiency, equity, and quality. Paradoxically, the main weakness of single payer systems lies in their effectiveness at cost control and the risks to equity and quality from under-funding.

In contrast, the allocation of resources and cost pressures in competitive health insurance markets are much harder to control. The incentives in such markets are to maintain market share, push up premiums, select for healthy low risk customers, and contain net expenditure. The supposed benefits of price competition in the marketplace can be largely avoided by competing through advertising, market segmentation, and brand promotion while obscuring price through complex plan variations.

The policy levers available to governments to promote equity and efficiency in competitive health insurance markets are weak or non-existent; weak control over efficiency generally leads to increasing pressure for government funding although still unaccountable for efficiency. However, the starkest and most recalcitrant weakness of health insurance markets concerns equity: equity regarding health care costs, access to care (including access to medicines) and quality of care.

The repeated references to 'benefit package' in WHO documents strongly suggests health insurance as the default mechanism for achieving universal health 'coverage'. Benefit packages place arbitrary and uniform restrictions on what is out and what is in for public subsidy.

One of the most critical differences between tax based health care and health insurance lies in the incidence of the cost burden. Tax based health care includes contributions from corporate tax and various tariffs as well as families through income tax and indirect taxation. In contrast health insurance premiums focus all of the burden on families.

PHM urges WHO to produce a full analysis of the costs and benefits of mixed service delivery and health insurance financing, including the regulatory requirements and management capacity needed to defend equity, efficiency and quality in each case.

7.2 Political declaration of 3rd HLM of UNGA on NCDs

In focus

The UNGA HLM on NCDs took place in Sept 2018 and adopted the Political Declaration ([A/RES/73/2](#)). WHA72 considered the Secretariat's report on the HLM ([A72/19](#)) and in Decision [WHA72\(11\)](#) the Assembly made a number of requests of the DG for further work.

In November 2019 the [Officers of the Board](#) decided to merge and integrate into this item the items proposed by the Government of Iraq (Early detection of noncommunicable diseases and their risk factors) and the Government of Thailand (Strengthening the control of harmful use of alcohol).

As a consequence the Board will consider four separate issues regarding NCDs:

- **Mental Health.** In Annex 1 of [EB146/7](#) the Board is presented with a menu of policy options and cost-effective interventions to promote mental health and well-being, with a view to updating Appendix 2 of the [comprehensive mental health action plan 2013–2030](#).
- **Air pollution.** In Annex 2 of [EB146/7](#) the Secretariat advises the Board of its intended next steps in the development of a menu of policy options to reduce the number of premature deaths from noncommunicable diseases attributed to air pollution (building on [WHA68.8](#) and the 2016 roadmap, in [A69/18](#)).
- **Alcohol.** In Annex 3 of [EB146/7](#) the Secretariat provides a review of progress in implementing the [global strategy to reduce the harmful use of alcohol](#) since its endorsement in 2010. In addition [EB146/7 Add.1](#) reports on the findings of the consultation around the global strategy to reduce the harmful use of alcohol which will feed into the DG's report to WHA73 in May 2020 on the way forward.
- **Early diagnosis and intervention for NCDs.** In Annex 4 of [EB146/7](#) the Secretariat provides a report on early diagnosis and intervention in NCDs (as proposed by Iraq).

Background

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

[Tracker links](#) to previous discussions of mental health.

[Tracker links](#) to previous discussions of air pollution.

See also [Norway Launches First-Ever Strategy By Major International Donor To Combat Non-Communicable Diseases](#) on Health Policy Watch, 22/11/2019 by Elaine Ruth Fletcher

PHM Comment

Mental health

In Annex 1 of [EB146/7](#) the Board is presented with a menu of policy options and cost-effective interventions to promote mental health and well-being, with a view to updating Appendix 2 of the [comprehensive mental health action plan 2013–2030](#).

The programming of mental health on the menu of discussions on non-communicable diseases is very welcome. However, the absence of any reference to post-traumatic stress disorder or addictive behaviour is striking.

The absence of any reference to post-traumatic stress disorder and to the mental health morbidity associated with it is concerning. Racism, traumatic journeys, risk exposure, violence, and loneliness make the mental health of refugees and asylum seekers a public health emergency with serious psychological consequences which cannot be ignored. In France, less than 32% of asylum applications were granted in 2017 while more than 57 thousands applications were rejected ([MdM & CPL](#) 2018). Other contributory causes of post-traumatic stress disorder include: the rise in the precariousness of employment contracts, domestic violence, unemployment, and social exclusion.

Austerity programs (including structural adjustment programs) increase unemployment and reduce social protection. Extractive industries displace and impoverish people, create or revive conflicts, steal people's future and wellbeing especially in the LMICs. Small farmers are being driven off their land by oil powered chemically drenched mechanised agribusiness. Social exclusion associated with intersecting oppressions (class, gender, ethnicity, caste and race) increases people's vulnerability.

Addictive behaviours, including gambling disorder, are not mentioned in EB146/7. However, a paper commissioned by WHO ([Abbott 2017](#)) concluded that:

The gambling-related burden of harm appears to be of similar magnitude to harm attributed to major depressive disorder and alcohol misuse and dependence. It is substantially higher than harm attributed to drug dependence disorder. Despite the global increase and extent of gambling-relating morbidity and harm, and long recognition of problem gambling as a mental health disorder, it has rarely been seen as a public health issue or priority. There is an urgent need to place gambling on national and international public health agendas and strengthen evidence-based policy and prevention strategies, as well as greatly extend early intervention and treatment provision. These measures are critical to reduce current and future harm and social costs associated with commercial gambling.

PHM urges the Executive Board to request the Director General to revise Annex 1 to include preventive, therapeutic, and rehabilitative responses to post-traumatic stress disorder and gambling disorder.

Annex 1 usefully identifies a range of mental health interventions which have been identified as 'cost-effective'. However, the methodology involved necessarily focuses on the defining elements of the intervention and not the health system context in which it may or may not be implemented.

In their pursuit of 'universal health coverage' WHO and its partners take a neutral position in relation to health system models, endorsing mixed public private health care delivery. However, the cost-effectiveness in practice of specific interventions depends greatly on the model of health care delivery in which they are to be implemented.

The lack of serious consideration of health system models in relation to the menu of interventions is a serious weakness which needs to be redressed.

PHM urges WHO to give full consideration to comprehensive PHC (publicly funded, organized and delivered) as a platform for delivering many of the interventions listed, including building awareness within communities and mobilizing community agency around mental health promotion.

Air pollution

In Annex 2 of [EB146/7](#) the Secretariat advises the Board of its intended next steps in the development of a menu of policy options to reduce the number of premature deaths from noncommunicable diseases attributed to air pollution (building on [WHA68.8](#) and the 2016 roadmap, in [A69/18](#)).

Air pollution being the fourth-highest cause of death in the world, after smoking, high blood pressure and poor diet, discussions on policy options to address the issue are of a high importance.

PHM supports the broad directions outlined in Annex 2 but urges further attention to:

1. The need for international regulation; air pollution as a public health emergency of international concern;
2. The capital investment needed for global public goods investment including taxation and North South transfers;
3. Opening up access to green technologies and associated R&D capacity;
4. Containing unsustainable growth in material throughput globally while mobilizing resources required for necessary infrastructure development in the global South;
5. Institutional reforms to strengthen transparency and integrity regarding energy policy making and implementation, nationally and internationally.
6. The need for PHC as a platform for building community awareness, mobilizing communities to drive local interventions (eg indoor air pollution) and to provide policy support for larger scale interventions.

International regulation

Simply focusing on local context and providing guidance for Member States (paragraph 9) to select interventions that are relevant to them will not address the international and transboundary dimensions of air pollution. Ambient air pollution is a public health emergency of international concern.

[Zhang et al 2017](#) estimate that the pollution emitted in China in 2007 resulted in about 65,000 premature deaths in other parts of the world. Conversely, they estimate that the consumption of Chinese goods in Europe and the United States is linked to more than 109,000 premature deaths in China. Price advantage is achieved by externalizing the cost of pollution (as a cost of production) to be borne by local communities.

PHM urges WHO to explore the use of the International Health Regulations to address the transboundary movement of air pollution and polluting industries.

Investing in clean energy

The introduction of clean technologies, in power generation and transport, calls for massive investment, which is particularly challenging for L&MICs.

Private sector investment in such transformations is conditional upon an expectation of profit. However, the control of air pollution, including greenhouse gases, is a global public good and in this respect the return on investment cannot be captured as private profit.

Generating funds for global public goods investment, including North to South transfers, will require a new approach to harmonized global taxation.

PHM urges WHO to promote consultation within the UN system with a view to estimating the investment funds needed and the appropriate taxation arrangements required.

Technology transfer

Much of the advanced technology (and associated R&D capacity) which will be required for a clean energy transformation (in North and South) is formally the property of transnational corporations or is embedded in their production systems. Either way it is only deployed where there is an expectation of profit; not for global public goods purposes.

Low standard / high protection patent regimes, linked with tight investor protection provisions, both of which are being aggressively driven through free trade agreements, are barriers to the governments of LMICs accessing and deploying advanced clean energy and transport technologies.

The scale and speed of the clean energy transformation which is needed will require an opening-up of access to technology and associated R&D. PHM calls upon WHO to promote consultation within the UN system with a view to opening up access to green technologies and associated R&D.

De-growth

Air pollution is closely associated with economic growth, in particular, growth in the extent of material transformation in the economy. In some degree, air pollution can be mitigated by changing the technologies involved. However, there also need to be global limits with respect to the absolute extent of such material transformations.

In view of the urgent need for infrastructure development in L&MICs the main burden of limiting growth must be borne by the HICs in the short to medium term.

PHM calls upon WHO to promote consultation within the UN system regarding the economic reforms, domestic and international, required to contain unsustainable growth in material throughput while mobilizing resources required for necessary infrastructure in the global South.

Protecting policy formation from corporate influence

Fossil fuel corporations have actively sought to prevent investment in clean energy and clean transport and to prevent the reform of the policy environments which shape investment. Vehicle manufacturers have actively sought to prevent emission controls and to avoid compliance where they have been mandated. There is a pressing need for greater transparency in domestic and international policy processes to project policy formation from corporate capture.

PHM calls upon WHO to promote consultation within the UN system regarding global structures which might strengthen transparency and integrity regarding energy policy formation and implementation.

Alcohol

In Annex 3 of [EB146/7](#) the Secretariat provides a review of progress in implementing the [global strategy to reduce the harmful use of alcohol](#) since its endorsement in 2010. In addition [EB146/7 Add.1](#) reports on the findings of the consultation around the global strategy which will feed into the DG's report to WHA73 in May 2020, including challenges, opportunities and the way forward.

A wide range of cost-effective policy options and interventions are highlighted in the [Global Strategy](#), in [Appendix 3](#) of the Global Action Plan on NCDs, in the [SAFER initiative](#), in the [Global Status Report of 2018](#), and in Annex 3 to [EB146/7](#) and the report of the consultation ([EB146/7 Add.1](#)). Best buys include marketing restrictions, regulated labelling, availability restrictions and price increases through excise taxes. Possible initiatives, beyond the best buys, include global regulation (comparable to the FCTC) and some kind of global alcohol taxation (both of which PHM would support).

However, the resources and political will required to implement the best buys have been lacking.

The Global Status report discusses the social and political factors behind the failure to act on the harms associated with alcohol use. These include the culturally embedded status of alcohol use in many societies, the power of alcohol marketing, competing interests within government (tax revenue, economic significance and employment), industry interference with policy making ([Section 6.2.2](#) of Global Status Report), the ideology of deregulation and the weakening of alcohol controls, and trade agreements which protect the alcohol industry from domestic regulation.

The lack of resources for alcohol control at the national level is mirrored at the global level. Recurring revenue shortfalls against WHO's budgeted expenditure on NCDs reflects the lack of willingness by donors to support action on alcohol harm and other NCDs. The consultation report conveys a view that technical capacity within WHO is insufficient at all levels, presumably as a consequence of these shortfalls. This has a disproportionate impact on L&MICs whose alcohol control frameworks and relevant technical capacity are generally weaker than those of HICs.

There are clearly limits on WHO's capacity to make an impact on alcohol harm. The best buys need to be legislated in domestic law. However, WHO could do much more in terms of holding countries to account for their action and or failure to act. The [Country Profiles](#) provided in the Global Status Report provide an overview of policies and interventions but much more detail is needed with evaluative comment and for the profiles need to be given much more publicity and prominence.

The accountability of MS governments in the face of their own domestic constituencies would be greatly strengthened by WHO building alliances with civil society organizations to both monitor and document policies and implementation and to publicise domestically how countries compare.

Likewise WHO could be doing more to hold industry to account. The Global Status Report includes a very useful discussion of the growing concentration and globalization of economic actors and strong influence of commercial interests in [Section 6.2.2](#). However, this kind of public exposure needs to be updated and given much more prominence. In particular the power of industry influence within particular countries needs to be included in Country Profiles.

The enactment of a global, legally-binding regulatory instrument on alcohol would protect domestic regulation from challenges arising from trade agreements and help to protect alcohol policy from corporate interference. PHM strongly supports the idea of a global law on alcohol at the intergovernmental level, modeled on the WHO Framework Convention on Tobacco Control.

Until now, NCD strategies receive only 1% of international health assistance and there have been recurring shortfalls in revenue for WHO's budgeted expenditure on NCDs which reflects a caution on the part of donors regarding any real action in this area.

In November 2019, Norway announced it will include a NCDs Strategy in its international development policy (see [Better health, Better lives](#)) allocating over 22 million US dollars for

2020. The Norway NCDs strategy sets out a plan for this work for the period 2020-2024 and focus on (i) strengthening primary health care services, (ii) addressing leading NCD risk factors like air pollution, tobacco and alcohol consumption and unhealthy diets, and, (iii) promoting better data and health information systems management. The country plans to act as a global driver and will cooperate with relevant actors in well-coordinated efforts to address NCDs.

PHM appreciates this initiative by the government of Norway which also supported the production of the Global Status Report.

However, WHO should not depend on the good offices of particular countries to find the resources necessary to address priority issues. PHM calls upon the MSs to lift the freeze on assessed contributions and calls upon bilateral donors to untie their contributions to WHO's budget.

Screening, early diagnosis and early intervention

In Annex 4 of [EB146/7](#) the Secretariat provides a report on early diagnosis and intervention in NCDs (as proposed by Iraq). Annex 4 reviews the logic of screening, early diagnosis and treatment; reviews a range of WHO publications which provide resources and advice on these matters across the field of NCDs. Under 'the Secretariat's response' the document promises more resources and technical guidance.

In para 4 of the Annex the report points out that:

countries' health systems already face significant and diverse challenges in their existing capacities: lack of access to affordable, safe, effective and good quality essential medicines, vaccines and other health products and medical devices for noncommunicable diseases; insufficiently trained or ill-equipped workforce; service-delivery models that are not patient-centred; inadequate investment in primary health care; and limited progress in implementing evidence-based programmes.

PHM strongly endorses this comment, particularly in relation to 'service delivery models which are not patient-centred' and 'inadequate investment in primary health care'.

Along the same lines the Secretariat (in para 17) calls for "due recognition to the potential harm of diverting resources towards programmes that have high costs and minimal population benefit".

Screening programs require centralized databases, information systems, reminders and monitoring and strong support from local clinicians. Early diagnosis and referral as necessary requires organized clinical information systems and smoothly operating effective referral networks.

The model of UHC, which WHO and its partners are promoting, encourages a prominent role for private sector providers despite the evidence that publicly organized and delivered programs are more efficient and effective when comparably funded.

Comprehensive PHC as an approach to prevent NCDs

In all four areas reviewed in EB146/7 progress against previous commitments has been insufficient to meet target 3.4 of the SDGs.

The potential role of comprehensive primary health care (publicly funded, organized and delivered) has been neglected in all of the four annexes included in EB146/7.

Comprehensive PHC supports integrated people centred health care, including for people with mental health or alcohol related needs, and provides for a balanced approach to screening and early diagnosis. Comprehensive PHC involves local PHC agencies and practitioners building partnerships with their communities and civil society organisations; partnerships which can help to drive cultural change (including in relation to mental health, air pollution and alcohol harm) as well as policy reform in all four areas.

PHM therefore calls on WHO to give a greater priority to strengthening comprehensive primary health care (publicly funded, organized and delivered) in all NCD strategies.

8. Global Vaccine Action Plan

In focus

In resolution [WHA70.14](#) (2017), the Health Assembly requested the Director-General to report on the achievements made towards the global vaccine action plans' goals and targets for 2020 and the feasibility of, and potential resource requirements for, eradication of measles and rubella. [EB146/8](#) reviews and presents the lessons learned from the global vaccine action plan, which provided an immunization vision and strategy for the decade 2011–2020.

The Board is invited to note the report and provide further guidance on next steps. There may be a draft resolution in the wings, commissioning a revised action plan for 2021-2030.

Document [EB146/8](#)

- [EB146/8](#) starts with a brief overview of the development of the Global Vaccine Action Plan (GVAP).
- [EB146/8](#) conveys an executive summary of [Global Vaccine Action Plan 2011-2020 Review and Lessons Learned Report](#) by the Strategic Advisory Group of Experts (SAGE) on Immunization, with a focus on achievements, shortfalls and lessons learned.
- Reflections and lessons learned from the SAGE report (2019):
 - Although many GVAP targets were not met, much progress was made during the Decade of Vaccines
 - GVAP did not take sufficient consideration of differences in individual countries' circumstances
 - NITAGs: A success story
 - Local innovation
 - Local research
 - GVAP goals remain relevant – but the remaining challenges are tough
 - Integrating disease-specific activities and national immunization programmes
 - Partnerships and integration – the expanding scope of immunization
 - Humanitarian emergencies and chronic fragility
 - GVAP created a global framework for immunization, but was unable to drive sufficient change to achieve its goals
 - Responding to emerging challenges
 - Spreading the word
 - Inclusion of R&D in GVAP was a major advance
 - GVAP highlighted the critical role of data and stimulated important initiatives to improve data quality and use for action
 - GVAP's monitoring and evaluation framework delivered many benefits, but did not achieve full accountability
- Para 16 summarises the SAGE high-level recommendations on a post-2020 immunization strategy:

- Build on GVAP’s lessons learned, ensuring more timely and comprehensive implementation at global, regional and national levels
- Have a key focus on countries
- Maintain the momentum towards GVAP’s goals
- Establish a governance model better able to turn strategy into action
- Promote long-term planning for the development and implementation of novel vaccine and other preventive innovations, to ensure populations benefit as rapidly as possible
- Promote use of data to stimulate and guide action and to inform decision-making
- Strengthen monitoring and evaluation at the national and sub-national level to promote greater accountability
- [EB146/8](#) also reports the feasibility of eradicating measles and rubella, based on the report of the October 2019 meeting of the SAGE (see document [WER,94,541-560](#)).
- Though it was not a mandate from the resolution WHA70.14 (2017), [EB146/8](#) also conveys an executive summary of the [Defeating Meningitis by 2030 a global roadmap report](#), with mentioning that “In 2018 the report by the Director-General on WHO’s Thirteenth General Programme of Work, 2019–2023 acknowledges defeating meningitis by 2030 as one of the four flagship global strategies to prevent high-threats infectious hazards.” (see document [A72/4](#)) Para 23 summarises the framework for meningitis prevention and control based on this roadmap report:
 - enhanced access to affordable vaccines
 - effective prophylactic measures and targeted control interventions
 - access to appropriate health care, early diagnosis and effective case management
 - strengthened surveillance and laboratory capacity for all the main causes of bacterial meningitis and their sequelae
 - effective systems for timely identification and management of sequelae and access to
 - appropriate support and care services for affected people and families
 - increased public and political awareness of the impact of meningitis
 - improved health-seeking behaviour and access to control measures
- The Board is invited to note the report and focus its deliberations on “how to take forward work on immunization and meningitis, thus ensuring the succession from the global vaccine action plan and framework for meningitis prevention and control.”

Background

The [GVAP 2011-2020](#) was adopted in [WHA65.17](#) in May 2012. A further resolution ([WHA68.6](#)) was adopted in May 2015 expressing concern about prices, transparency, shortages and scepticism and urging MSs to strengthen their efforts and asking the DG to investigate increased funding, price transparency, local production and delivery systems.

Further reports on GVAP were submitted to the Assembly in 2016 ([A69/34](#)) and 2018 ([A71/39](#)).

Shortages of medicines and vaccines were discussed at WHA70 in May 2017 ([Item13.3](#)) and that discussion morphed into the debate over transparency (pricing, costs of production, clinical trials) at WHA72 in May 2019 ([Item 11.7](#)) leading to the adoption of [WHA72.8](#) on market transparency.

See [Tracker links](#) to recent discussions of vaccines and medicines. See in particular the Strategic Advisory Group of Experts on Immunisation report on [GVAP 2011-2020 Review and Lessons Learned](#).

PHM Comment

Equity should continue to be advocated for, on the basis of health rights and justice

A decade ago, major inequities in access and coverage, which existed both between and within countries, led to the vision of the GVAP. Equity was one of the six Guiding Principles as well as one of the six Strategic Objectives (Objective 3. The benefits of immunization are equitably extended to all people).

During the last decade, while coverage has improved for numerous vaccines, many inequities remain, within as well as between countries. On the other hand, according to the [SAGE report \(2019\)](#), stakeholders perceive that GVAP aspired to achieve similar goals for all countries, irrespective of their current status, on the basis of the (misapplication of the) principle of equity.

In fact, there has been not enough action to address inequities and emergencies in spite of these 'equity aspiration' of GVAP. [SAGE report \(2019\)](#) notes that existing strategies (such as Reach Every Community) do not address the needs of those in transit although recently new initiatives and mechanisms have been launched, including Gavi's change of policy, for people affected by disease outbreaks and humanitarian crises. (See [MSF's press release](#) on 12 April 2019 "Humanitarian mechanism for vaccines used for first time in Europe to counter high prices".)

Despite these contexts, [EB146/8](#) only says that:

"the lack of progress in a relatively small number of countries, generally affected by chronic conflict or political instability, masks significant progress made during the decade in a large number of diverse countries."

"the experience of the past decade suggests that elimination goals will ultimately depend on strong national immunization programmes that can equitably deliver high immunization coverage" ... "Progress relies critically on ... increased commitment to achieving high, equitable immunization coverage, ..."

It doesn't mention 'rights' or 'justice', even though the GVAP already clarified that equitable access to immunization is a core component of the right to health (Guiding Principle 3. Equity).

The [SAGE report \(2019\)](#) rightly notes that:

“A focus on global averages masked considerable national variation, ... Global averages also provided limited insight into underlying causes and potential appropriate corrective actions. In addition, attention to national-level indicators masked significant disparities at sub-national levels.”

‘Equity’ should continue to be advocated in the post-2020 immunization strategy, on the basis of health rights and justice, rather than being used as the justification for the lack of progress, or as an argument for raising ‘averages’.

‘Causes of the causes’ approach should be integrated into the post-2020 immunization strategy

[EB146/8](#) notes that:

“Urbanization and its accelerating pace, migration and displacement, conflict and political instability, vaccine unaffordability in middle-income countries, unexpected vaccine supply shortages, and rising vaccine hesitancy have all presented major challenges throughout the decade. Even though these challenges have been recognized, the global vaccine action plan has limited levers to influence responses to them.”

As a response to this, it suggests that the post-2020 immunization strategy should “encourage greater collaboration and integration within and outside the health sector.” In fact, while “building linkages outside the health sector” was already one of the GVAP’s objectives, progress has been limited.

It is evident that these ‘challenges’ are not merely issues of ‘relationships’, but rather issues of ‘causes of the causes.’ This perspective should be integrated into the post-2020 immunization strategy, rather than being used for the justification of lack of progress. Not only because “Urbanization and its accelerating pace, migration and displacement, conflict and political instability, vaccine unaffordability in middle-income countries, unexpected vaccine supply shortages, and rising vaccine hesitancy” all presented major challenges through the decade, but will be persisting in the next decade.

Vaccine unaffordability: Market transparency should be the first step

[SAGE report \(2019\)](#) says that:

“Middle-income countries that are not eligible for Gavi support have introduced fewer vaccines due in part to slow adoption of newer, more costly vaccines.” (On the progress of Goal 4 Develop and introduce new and improved vaccines and technologies)

“Middle-income countries still report that the cost of vaccines is a major obstacle to their introduction. Such countries pay higher prices for vaccines, ... To help address their needs, the Market Information for Access to Vaccines initiative aims to enhance vaccine-pricing transparency, ...” (On the progress of Strategic Objective 5: Sustainable funding and vaccine supply)

“GVAP’s monitoring and evaluation framework delivered many benefits... Countries used these discussions to raise issues such as affordability of new vaccines for middle-income countries.” (On the lessons learned from GVAP)

But [EB146/8](#) has no comment at all about price and market transparency, but only about “vaccine unaffordability in middle-income countries.” Further considering the former adoption of [WHA68.6](#) (2015) and [WHA72.8](#) (2019) on market transparency, a post-2020 immunization strategy should deal with price transparency for all MSs including non-Gavi middle-income countries, to make them negotiate the affordable price. (see [Global Health Watch \(GHW\) 5 chapter on Gavi](#))

A more comprehensive approach to R&D and production is needed: Local research and production

In 2018 the report by the Director-General on Access to Essential Medicines and Vaccines (in Annex, see [A71/12](#)), it was noted that:

“Access to safe, effective and quality medicines and vaccines requires above all sufficient political will at the national level. It also requires a comprehensive health-systems approach that addresses all stages of the pharmaceutical value chain, including: needs-based research, development and innovation; public health-oriented intellectual property and trade policies; manufacturing processes and systems, including strategic and sustainable local production that ensures quality products; pricing policies and coverage schemes that contribute to the attainment of universal health coverage; integrity and efficiency in procurement and supply chain management; and appropriate selection, prescribing and use.”

[SAGE report \(2019\)](#) says that:

“For the first time, GVAP included a focus on R&D, including vaccine technologies and new vaccine development – where significant progress has been made. Although local research capacity and vaccine production capabilities in some middle-income countries have significantly increased, there is still much progress to be made to encourage local involvement in vaccine R&D and production, especially in low-income countries of disease-endemic regions”

However, the SAGE recommendations on the post-2020 immunization strategy do not place enough emphasis on local research and production. # A more comprehensive approach to R&D and production is needed including local research and production, based on the preexisting studies that WHO has already undertaken. (See more in [A71/12](#) on Strategic and sustainable local production, with lots of references as footnotes.)

Economic reform and tax reform are key to recruiting more domestic resources

[SAGE report \(2019\)](#) says that:

“...contrary to many expectations, GVAP did not come with additional resources. This led to targets and timelines that were perceived by some countries to be unrealistic, limiting buy in to GVAP’s aims.”

“Middle-income countries ineligible for Gavi funding were assumed to be able to self-support their immunization programmes and had little access to financial or technical support, contributing to the slower introduction of new vaccines in such countries.”

Despite these diagnoses, [EB146/8](#) still leans on “national commitment supported by domestic resources.” To mobilise more domestic resources, other things being equal, economic reform and tax reform are key. (See GHW5 chapter on [Gavi and the Global Fund](#) for details on public funding to, and tax exemption for, PPPs.)

Priority setting for the next decade: why meningitis?

It appears that meningitis is included in [EB146/8](#) because of the availability of a new vaccine. [SAGE report \(2019\)](#) says that “Particularly notable over the decade was the widespread introduction of a meningococcal group A vaccine (‘MenAfriVac’), designed specifically for use in Africa.”

[SAGE report \(2019\)](#) also notes that “Partners, in light of their own strategic priorities, drove progress in some areas without prioritizing others.” But the priority setting should be set according to the national contexts, by the NITAGs, as SAGE report (2019) recommends, as well as [PHM previously commented](#) in 2018 for the WHA71.

Closer integration of immunization with primary health care

PHM welcomes the recognition in both the SAGE Report and EB146/8 of the central importance of closer integration of immunization within comprehensive PHC.

The delivery of immunisation services depends on and lies within the remit of the primary care sector while technical guidance lies with NITAGs and public health authorities. However, community confidence in immunization depends on confidence in efficacy and safety and in the integrity of technical leadership.

In previous comments on GVAP, PHM has emphasised the need for vaccine prioritisation to be determined in relation to local circumstances (including disease burden and health system capacity) rather than ‘one size fits all’. PHM has also called for assiduous adverse event surveillance and assessment. If PHC practitioners and agencies are familiar with, and confident in, the technical leadership, they will enthusiastically share their confidence with their communities.

The proposed Operational Framework for PHC, as promoted by the Secretariat, includes three components: (a) multisectoral policy and action; (b) empowering people and communities; and (c) putting primary care and essential public health functions at the core of integrated health

services. 'Empowering people and communities', in relation to immunization, involves strengthening the accountability of immunization leadership and delivery to local communities.

A revised action plan for WHO must give priority to closer integration of immunization within comprehensive primary health care.

9. Accelerating the elimination of cervical cancer as a global public health problem

In focus

This item appears as a consequence of Decision [EB144\(2\)](#) in Jan 2018 which requested the Director-General to develop a draft global strategy to accelerate cervical cancer elimination, with clear goals and targets for the period 2020–2030.

The Board is invited to consider the draft strategy (in [EB146/9](#)) and provide further guidance.

Background

See Secretariat paper [EB144/28](#) submitted to EB144, debate at [PSR12](#) and [PSR13](#), and PHM comment [here](#).

See summary of [regional committee discussions](#) of the global strategy to accelerate cervical cancer elimination.

PHM Comment

Cervical Cancer is a serious public health issue and PHM commends WHO for this initiative.

PHM notes the progress made on developing the draft document on '[Draft global strategy towards eliminating cervical cancer as a public health problem](#)', reported upon in [EB146/9](#). PHM appreciates the recognition of existing inequity between and within countries. While the strategy document sets out a good background to the issue and has tried to address most aspects of the issue, there are certain omissions and a few concerns, mainly in terms of the actions and strategies proposed.

Vaccination

Para 10 of EB146/9 proposes a combination of “intensive vaccination against human papillomavirus, screening for and treatment of pre-cancerous lesions and management of invasive cervical cancer”, along with other actions.

Para 12 of the DG’s Report talks about vaccination against human papillomavirus and, in relation to this, the strategy document emphasizes the need to address vaccine hesitancy. However, it needs to be recognized that public confidence in vaccines can be achieved only if the policy recommendation emerges out of robust and independent research (see [Jørgensen et al, 2018](#)). The WHO and member countries must consider the evidence on unethical clinical trials (see [Sengupta et al 2011](#)), non-transparency in research on HPV vaccines and on the issue of conflict of interest in promoting HPV vaccines. Therefore the strategic actions should

include country-specific transparent and ethical research on the public health merit of the HPV vaccines.

Screening

Para 14 suggests that screening should be built “into the basic package of services at the primary health care level”. The term ‘basic package of services’ implies some form of health insurance as the default arrangement for health care financing (that which is in the ‘package’ will be funded) and mixed, public private, service delivery. PHM regards WHO’s endorsement of insurance funding and mixed service delivery as its preferred approach to ‘universal health coverage’ as most regrettable. A well conducted screening program requires coordination, quality assurance, a robust information system and reliable feedback and follow up. Private sector participation in such a program can be very difficult to organize.

Cervical cancer screening needs to be integrated into the overall program of services for women’s health in the public health system. The services/clinics need to flow from general to specific, i.e. located within services/clinics for women’s health issues and sexual and reproductive health services (including screening services for RTI/STI). This would ensure universal access, continuity and it would also deal with any issue of stigma.

As mentioned in the draft strategy document, visual inspection of the cervix with acetic acid (VIA) is a low-cost and effective way of screening. There needs to be a higher emphasis on this as it could be easily made available at the village level through village nurses and other village health workers. Therefore appropriate recruitment, training, equipment and other support need to be made provided for. Cytology based screening and HPV testing should be made available at higher-levels of health facilities (district/provincial/regional levels).

Treatment

PHM agrees with the statement in the draft strategy document that “screening women without access to treatment is unethical” (page 18) and appreciates that WHO is cognizant of it. It must be emphasized and reiterated in Para 14 of the Report that screening and treatment programmes need to be rolled out together. As with screening, treatment of cervical cancer too needs to be integrated into the primary health care approach and through the government health system. The expectation by WHO and partners that insurance funded mixed service delivery for primary care (as part of UHC) would be very difficult to accomplish. The private sector in most LMICs is generally not providing these services and wherever they are, they are very expensive and only accessible to the upper income strata. Neglecting the strengthening of public health care for provision of these services and instead expecting the private sector to take up the task is likely to delay and undermine the achievement of the proposed targets. The elimination of cervical cancer as a public health issue will happen only if countries’ public sector health systems are strengthened, through ensuring financial protection, referral networks, data systems, infrastructure and workforce development and so on, to adequately respond and act on it.

PHM deplores the statement in the draft strategy document that, “Private sector efficiencies in management can be leveraged to improve work flow and output in the public sector” (page 16).

This recommendation is clearly ideological and not based on any evidence. This sentence needs to be deleted.

HIV services

In Para 5 the higher incidence of cervical cancer in association with HIV is noted. However, the Report needs to also recognize and address the huge gaps in availability and access to HIV screening and treatment, especially in LMICs. This again points to the importance of strengthening the government health systems to respond comprehensively.

Vaccine procurement and production

The Report seems unduly optimistic (Para 13) about ‘market shaping’ initiatives to ‘optimise price and supply’ of vaccines, including encouraging more manufacturers to enter the market.

Interestingly, the Secretariat does not appear to have taken up the suggestion from several [regional committees](#) regarding pooled procurement of vaccines as a way of addressing affordability.

The ongoing challenges regarding research, development, production and distribution of medicines and vaccines have been repeatedly considered by WHO’s governing bodies although progress has been glacial (see [Tracker links](#) to access to medicines discussions). Barriers include industry R&D driven by profit expectations rather than public health needs and trade agreements and domestic legislation which prevent the full utilization of the flexibilities provided for in the TRIPS Agreement.

The strategic actions for the cervical cancer strategy need to include action on investment in public sector research and manufacturing along with addressing the problems with trade agreements.

The ‘investment case’ and donor support

Para 21 states that “The interventions required to meet the 90-70-90 targets would not only lead to elimination but would also be cost-effective in a clear majority of the 78 low- and lower-middle-income countries”. This most probably refers to the calculations done in Annexure 1 of the draft strategy document titled ‘Costing, financing and investment case’.

The clear implication of developing an ‘investment case’ is that such a case will persuade donors to contribute to the prevention and treatment of cervical cancer. This raises questions about the role of international financial assistance in relation to a program such as cervical cancer prevention and treatment. There would be a case for donors to contribute to the development of public sector vaccine research, development and production. However, the prospect of donor support for screening and treatment raises serious concerns regarding the vertical siloisation of a program that must be closely integrated into general primary care services and hospital care.

In relation to domestic resource mobilization, investment in any particular disease is assessed in relation to national disease burden/profile (eg HIV comorbidity), health system capacity (eg

immunization capacity, laboratory capacity), and fiscal resources. However, priority setting is a political as well as technical task which raises questions about the inclusion of women's voices in the priority setting process.

In Para 22, there needs to be a higher emphasis on involvement of the community and affected persons in planning, implementation and monitoring of the programme and of the process of health systems strengthening, rather than simply participating as beneficiaries or mobilisers.

The report and strategy document need to emphasise that action on cervical cancer is an imperative and a duty for the government and an issue of justice and health right for the community.

Poverty, inequality and women's rights

The strategy document recognizes that the burden of cervical cancer borne disproportionately by poorer women (as well as women in poorer countries) but it is silent in terms of addressing the inequalities which lie behind different incidence rates.

In many settings, the lack of funding for and programmatic focus on cervical cancer is part of a broader neglect of women's health. Accordingly, implementing this cervical cancer strategy needs to be linked with action on gender equality and women's rights (including sexual and reproductive rights). Among the 'strategic actions' for this strategy, action on poverty, gender inequality and other social determinants of health, needs to be added.

10. Ending TB

In focus

Pursuant to resolutions [WHA67.1](#) (see also the [Global 'End TB' Strategy in Annex 1](#)) and [WHA71.3](#) (2018), the Director-General submits two reports on tuberculosis.

The first ([EB146/10](#)) contains a report on progress in implementing the End TB Strategy and towards its targets for 2030 and 2035 with an assessment of progress in implementing the commitments set forth in the [political declaration](#) of the United Nations high-level meeting on ending tuberculosis in 2018.

Note the weight placed on the [multisectoral accountability framework](#) (MAF-TB) in terms of driving implementation.

The second report ([EB146/11](#)) summarizes a comprehensive draft global strategy on tuberculosis research and innovation ([full strategy here](#)). The Board is invited to note the reports, provide further guidance as appropriate, and consider a draft decision.

Background

Progress in the implementation of the End TB Strategy

TB strategy adopted in May 2014 in [WHA67.1](#). Full strategy [here](#) has four principles and three pillars:

<p>Principles</p> <ol style="list-style-type: none"> 1. Government stewardship and accountability, with monitoring and evaluation 2. Strong coalition with civil society organizations and communities 3. Protection and promotion of human rights, ethics and equity 4. Adaptation of the strategy and targets at country level, with global collaboration
<p>Pillars and components</p>
<p>1. INTEGRATED, PATIENT-CENTRED CARE AND PREVENTION</p> <ol style="list-style-type: none"> A. Early diagnosis of tuberculosis including universal drug-susceptibility testing, and systematic screening of contacts and high-risk groups B. Treatment of all people with tuberculosis including drug-resistant tuberculosis, and patient support C. Collaborative tuberculosis/HIV activities, and management of comorbidities D. Preventive treatment of persons at high risk, and vaccination against tuberculosis
<p>2. BOLD POLICIES AND SUPPORTIVE SYSTEMS</p> <ol style="list-style-type: none"> A. Political commitment with adequate resources for tuberculosis care and prevention B. Engagement of communities, civil society organizations, and public and private care providers C. Universal health coverage policy, and regulatory frameworks for case notification, vital registration, quality and rational use of medicines, and infection control

D. Social protection, poverty alleviation and actions on other determinants of tuberculosis

3. INTENSIFIED RESEARCH AND INNOVATION

- A. Discovery, development and rapid uptake of new tools, interventions and strategies
- B. Research to optimize implementation and impact, and promote innovations

Draft global strategy for TB R&D

[EB146/11](#) presents a draft global strategy for TB R&D as requested in [WHA71.3](#). The draft strategy is summarised in EB146/11 and presented in full [here](#).

The draft strategy acknowledges the existing limitations in R&D capacity and performance and their significance in the continuing TB epidemic. The strategy addresses health system innovation as well as the need for medicines and diagnostics.

Some of the barriers to the necessary R&D build up which are identified in the draft strategy are:

- regulatory barriers and the management of innovation in health care practice;
- institutional weaknesses in research capacity and links between academia and health service delivery; and
- lack of funding for R&D.

The lack of funding for TB R&D is attributed to the low priority assigned to TB in rich country research (where most of the basic research capacity is located), to the lack of market incentives to encourage research-based pharmaceutical corporations to invest in TB, and to the lack of public funding to supplement private sector investment (and hence the support for public private partnerships).

The strategy usefully reviews priorities for the development of diagnostics, medicines and vaccines. The review of priorities for health system innovation is largely restricted to the needs of TB specific programs.

The draft strategy incorporates:

- regulatory strengthening (including capacity for prompt review of applications for marketing approval or clinical trials; also regulatory harmonisation and regulatory policies to guide data and material sharing, including the transfer of research reagents and clinical specimens);
- commercial reform (reducing trade and distribution markups on prices);
- strengthening public private partnerships, including product development partnerships;
- strengthening of domestic R&D capacity, including innovation, including, inter alia through better linking between research institutions and TB programs;
- domestic funding targets for operational/implementation research (particularly in those high burden countries with established R&D capacity);
- innovative financing mechanisms (including direct public funding, tax concessions milestone prizes, advanced market commitments);

- improved data sharing (open access to research and open data for research - for publicly funded research), publicly searchable patent databases; and transparency and public disclosure of clinical trials data;
- improved reporting, information systems and monitoring;
- increased commitment to R&D on the part of global financing bodies;
- “developing policies on trade, health and intellectual property through multisectoral collaborative frameworks, to help address access and innovation simultaneously” (including ‘open access to research data and IP’ generated through international funding);
- national strategies and roadmaps;
- monitoring and evaluation of policy implementation; and
- collaboration among all stakeholders, including North South and South South collaboration.

The draft strategy mentions the importance of implementing WHO’s [Roadmap on access to medicines and vaccines 2019-2023](#) and the [Global Strategy](#) and [Plan of Action](#) on Public Health, Innovation and Intellectual Property but EB146/11 does not mention these.

The Board is invited to endorse the draft global strategy.

Other resources

- [Tracker links](#) to recent discussions of TB.
- Secretariat [TB index page](#).
- [Moscow conference](#) Nov 2017
- Preparatory [discussion at WHA71](#) (for HLM at UNGA) (May 2018)
- Political declaration of HLM on TB (26 Sept 2018) adopted by the UNGA (10 Oct 2018) as [Resolution A/RES/73/3](#).
- Follow up [discussion at WHA72](#) (May 2019).
- Release of [Global TB Report 2019](#) in October 2019
- See summary of [regional committee discussions](#) of the comprehensive draft global strategy on tuberculosis research and innovation

PHM Comment

Implementation of End TB strategy

It is evident from [EB146/10](#) that the End TB strategy is failing. The shortfalls in the targets are themselves disappointing but in absolute terms the global burden of TB is static if not increasing:

- the reduction in TB incidence and mortality is well below the targets set in the Strategy;
- TB households are facing catastrophic health care costs: between 27-83%; 67-100% for drug resistant TB (or are not seeking treatment);
- There is an estimated annual gap of around 3m people who are not registered and not treated.

EB146/10 reports what the WHO Secretariat is doing in relation to the four principles, three pillars and ten components and reports a number of positive signs including improved medicines and diagnostics, including medicines for drug resistant TB. The report hints at but does not explore the underlying barriers to successful implementation of the strategy.

The continuing TB epidemic reflects health system weaknesses (including huge out of pocket costs for treatment); failure to act on the social determinants of the epidemic; and weak accountability for implementation.

EB146/10 mentions the Multisectoral Accountability Framework briefly: “its implementation *would* allow policy-makers to learn from ongoing efforts, and from the exchange of experiences and good practices across countries”. The use of ‘would’ here does not sound very confident.

Weak health systems

Weak health systems, in particular weak primary health care, jeopardise case finding, supportive treatment regimes, and case follow up and monitoring. PHM particularly notes that shortfalls in the health workforce are not mentioned in the report. Health workforce is critical for the implementation of the strategy and it is important that WHO gives priority to the strengthening and equitable distribution of health workforce.

WHO’s insistence, in its UHC rhetoric, that mixed (public and private) health service provision is compatible with effective health care, in this case effective TB control, is not credible. The End TB strategy repeatedly refers to engaging the private sector but implementing a TB control program through the private sector require well resourced program management and appropriate organisational support which in many cases is just not available. The preference of private sector providers to cluster in affluent areas is a major contributor to the poor distribution of health care resources and the shortages of skilled and motivated health workers in rural communities and informal settlements. PHM urges the MS to strengthen public health systems within the context of comprehensive primary health care and improve health care access.

The other major barrier on the health care side is the cost of medicines (particularly medicines for resistant TB), whether met through out of pocket payment or public subsidy. This underlines the importance of WHO’s work on access to medicines and the culpability of those who continue to obstruct effective action in this space. There is nothing in the Multisectoral Accountability Framework which might hold to account those who continue to prioritise Pharma profits over affordability of medicines.

At another level of scale the neoliberal program of small government, low taxes and austerity is responsible for limits on fiscal capacity, for either health service development or underwriting the cost of essential medicines.

Multisectoral action on the social determination of tuberculosis morbidity

The second challenge for effective implementation of the End TB strategy are the barriers to action on the social determinants of the TB epidemic.

The [End TB strategy](#) acknowledges the social determinants of TB:

Proposed interventions include reducing poverty, ensuring food security, and improving living and working conditions as well as interventions to address direct risk factors such as tobacco control, reduction of harmful alcohol use, and diabetes care and prevention. Tuberculosis prevention will also require actions on the part of governments in order to help to reduce vulnerabilities and risks among people most susceptible to the disease.

The strategy goes on to call for multisectoral action, political commitment and adequate resources.

EB146/10 reports that, of the estimated 10m new cases per year, 2.3m are attributable to undernourishment, 0.9m to smoking, 0.8m to alcohol abuse, 0.8m to HIV and 0.4m to diabetes; a total of 5.2m. There is no estimate of attributable fraction due to crowded housing, exposure in prisons, indoor air pollution or occupational dust exposure, although these are mentioned in the End TB strategy (and the draft R&D strategy).

Many governments, especially in the TB high burden countries, still fail to address the basic social determinants of (ill-)health, including TB, such as poor housing, undernutrition, occupational exposure to dust, and HIV control, which creates an environment for TB to easily spread.

These risk factors point to the importance of multisectoral action driven by political commitment, and multistakeholder buy-in as emphasised in the strategy. What the End TB strategy does not address is the political economy of poverty, inequality and austerity. The continuing epidemic is closely linked to the continuing and deepening inequalities between and within countries. In most of the high burden countries the majority of people live in impoverished communities including displacement settlements.

Accountability

We note the references to SDG 17 in the Multisectoral Accountability Framework which notionally addresses 'the global partnership for sustainable development' but the targets which are cited are largely about information systems and do not promise any progress with respect to equitable and sustainable economic development. Actually going nowhere.

Liberalised transnational capitalism is widening the gap between those people and countries who are well placed in global value chains and those countries and people who are excluded, who continue to carry the burdens of malnutrition, poor housing, occupational hazard exposure, and poverty and the financial and other access barriers which prevent them accessing care. Neoliberal austerity is restricting fiscal capacity and limiting health systems investment.

PHM urges MSs to implement bold policies to develop effective health services, promote affordable medicines and address social determinants of health and inequities which favour the continued prevalence of TB.

PHM urges MSs to acknowledge and address the global economic and political pressures which continue to drive inequality, poverty, displacement, and austerity while protecting the interests of the large corporations, including Pharma.

Draft global strategy for TB R&D

The global strategy on TB R&D will be a very useful instrument.

PHM looks forward to seeing the final draft adopted.

In the present draft PHM particularly appreciates:

- the emphasis on data sharing (including 'open access to research data and IP' generated through international funding) although the draft does not mention the 2019 [Transparency resolution](#); and
- the endorsement of WHO's [Roadmap on access to medicines and vaccines 2019-2023](#) and the [Global Strategy](#) and [Plan of Action](#) on Public Health, Innovation and Intellectual Property;
- the recommendations regarding capacity building for research, development and health service innovations, including strengthening the links between research institutions and service delivery programs.

PHM has concerns about a number of issues in the present draft and urges MSs to clarify and improve these proposed commitments before forwarding the draft to the Assembly.

Scope

The scope of the draft strategy includes basic research into medicines, vaccines and diagnostics and operational research into health care delivery issues. These are all clearly vital. However the draft strategy fails to fully consider the need for research into the social determinants of the TB epidemic (including undernourishment, smoking, alcohol abuse, HIV, diabetes, crowded housing, exposure in prisons, indoor air pollution or occupational dust exposure). It fails to acknowledge or address the global economic and political pressures which continue to drive inequality, poverty, displacement, and austerity (all critical drivers of the TB epidemic) while protecting the interests of the pharmaceutical and vaccine manufacturers.

WHO strategies, by themselves, are unlikely to resolve these social determinants and their economic and political drivers, but the first step in addressing them is to describe and analyse them and to report on 'best practice' in addressing them.

Research funding and IP

PHM appreciates the clarity of the draft regarding market failure in mobilising investment for TB research and innovation and the need to reform the IP based research funding ecosystem. In this respect PHM appreciates the reference to milestone prizes. However, the absence of any explicit references to delinking and the recommendations of the [UN High Level Panel on Access to Medicines](#) is disappointing.

In particular we regret the lack of reference to the need for countries to fully implement the flexibilities available in the TRIPS Agreement to improve the affordability of medicines (in particular medicines for DR-TB).

Transparency

PHM recognises that product development partnerships can play a useful role in promoting research in situations of market failure. However, PHM urges that organisations funding PDPs make open access publishing and open patenting conditional upon receipt of such funds.

PHM urges much stronger reference to the need for transparency with respect to private sector research and development costs. Estimates of R&D costs published by the pharmaceutical industry are generally wildly inflated and not accompanied by publication of the raw data (if any). If public support for private sector research is based on these estimates it will be essentially contributing to marketing costs and profits.

PHM appreciates the references to open patents and new policies on IP. In para 86 the draft highlights the patenting of specific medicines as a barrier to operational research directed to determining the most efficacious treatment regimes.

PHM urges high burden TB countries to develop appropriate amendments to both the draft strategy and the draft decision to incorporate these suggested improvements into the strategy as finally adopted.

11. Epilepsy

In focus

In [EB146/1 \(annotated\)](#) the Secretariat has advised that:

Following the agreement of the Board at its 144th session to include this item on the provisional agenda of the present session, the Director-General will submit a report ([EB146/12](#)) summarizing the latest available evidence on the burden of epilepsy, the public health response required at global, regional and national levels, the Secretariat's main activities over recent years, and the way forward. The Board will be invited to note the report and provide further guidance as appropriate.

In [EB146/12](#) the Secretariat highlights some of the findings in the recently published [epilepsy report](#) (which addresses requests made of the DG in [WHA68.20](#)) and suggests that the Board focus on:

- ways to close the treatment gap, which remains significant despite the availability of cost effective treatment (antiseizure medication);
- actions that may be taken by Member States, the Secretariat and other partners to tackle the health, social and public impact of epilepsy.

Background

The Assembly last considered Epilepsy at WHA68 (May 2015) and adopted [WHA68.20](#). The debate ([B8](#)) was informed by [A68/12](#). PHM's comment is [here](#).

WHA68.20 made a couple of requests to the DG and requested a report back at WHA71 (see Progress Reports in [A71/41 Rev.2](#)).

WHO's report [Epilepsy: a public health imperative](#) published June 2019 address the requests made in WHA68.20.

PHM Comment

The Secretariat report ([EB146/12](#)), highlights the magnitude of the epilepsy as a public health problem, the adverse consequences it has on the quality of life of those affected, the social stigma and discrimination that people, especially children, with epilepsy face, and the financial hardships that families undergo.

As we commented in 2015 (PHM comment on [A68/12 here](#)) much of the neglect of epilepsy within public health systems is due to the selective healthcare policies imposed under structural adjustment driven health sector reforms of the nineties. But we highlight a concern that even under the UHC approach, the nationally selected lists of diseases that constitute the essential service packages are defined too narrowly and they quite often fail to include epilepsy, despite the huge burden of disease it represents. Both the terms NCDs and mental health can be taken to include epilepsy, but quite often they do not.

Laudably the report emphasizes the importance of integration with primary health care systems (para 24), but regrettably when specific analysis of treatment gaps are presented (para 8) or progress in implementing the decisions on epilepsy are reported (para 14, 19) it still reads much like a vertical program.

Thus when referring to shortage of staff, the density of neurologists should not be projected in isolation as the critical barrier for referral services in LMICs. Access to the general physician and to the family medicine specialist should be the main strategy of providing access to specialist skills. General duty basic medical officers could also be trained through short term courses to have the requisite specialist skills for referral services. Since psychiatrists and cardiologists are similarly in short supply, such a “basic specialist skills” approach would provide referral support for all NCDs and mental health including epilepsy rather than a neurologist specific one. An exclusive emphasis on neurologists could discourage nations from including epilepsy in their package of essential services under UHC- because creating the required number of neurologists is far beyond what most nations can achieve even in a decade. A suggestion to create epilepsy specialists in the main June 2019 publication (pg 46) is even more fraught although as part of the research base in advanced tertiary care centers they would have a role. If we have epilepsy specialists and neurologists dispersed at the district level, it would be difficult for them even to retain their specialist skills.

When referring to access to medicines (para 8) no mention is made of developing robust public systems of procurement and distribution which many LMICs have shown is feasible and very efficient and cost saving. (Thailand, Tamil Nadu and Rajasthan in India). The problem of access to medicines, especially medicines like phenobarbital, which are restricted and the problems of local markets making use of shortages to increase prices can be addressed only by the economies of scale and quality assurance that nation wide or provincial level procurement can provide. It is unlikely that the problem of access to medicine for seizures can be solved separately from the problem of access to all essential medicines. Yet the report does not reflect this understanding.

Similarly the failure to follow up or adhere to medications, as we know from experience with TB and HIV control programs, depends not only on addressing stigma but combining this with delivery systems that can provide delivery of medicines and follow up care close to home- in the nearest health post of sub-center (see para 8). Too often the non-medical costs in travel and labour time lost in accessing care from a district hospital is what becomes a barrier to access to medicines, even if they are made available free. When 70% of epilepsy patients can become seizure free and when currently over 75% in LMICs do not access full treatment- this would be one of the most important steps required.

Reports of progress (in para 18 and 19), while most welcome, do read as if these are vertical programs. Instead the key indicator should be the number of nations and population covered by health system improvement measures where care for epilepsy is part of the basic package of assured services and where access to medicines at the most basic primary health facility has been assured. All nations must ensure that epilepsy is a part of their minimum set of assured services in UHC programs and this should be the first and most basic indicator that WHO could

use to measure progress. We do not know whether the nations reporting starting up of specific epilepsy control programs have taken parallel measures to include epilepsy in the assured set of basic services.

The absence of any information on progress in addressing the preventable causes of epilepsy thereby leading to a reduction in incidence of new cases - especially for neurological infections including encephalitis and neuro-cysticercosis is a matter of concern. This should be addressed by including this in the monitoring and public management protocols.

Survey data on incidence of new cases is also more than a decade old in most nations from where it is reported. Data on incidence, prevalence of epilepsy, mortality due to epilepsy and proportion on epilepsy care needs to be reported from all nations.

The impact of trade negotiations and the impact of trade agreements on access to newer drugs through intellectual property restrictions should be included as part of any indicator/evaluation.

12. Integrated, people-centred eye care, including preventable blindness and impaired vision

In focus

In [EB146/1 \(annotated\)](#) the Secretariat advises that [EB146/13](#) outlines the rationale for action to integrate the delivery of people-centred eye care services into the health system, to reduce inequities to access these services, and to enable health systems to respond to the projected increase in eye conditions.

The report draws on the 2019 [WHO World report on vision](#). The Board is invited to note the report and provide guidance, for instance on the next steps to accelerate the implementation of integrated people-centred eye care.

Note the decision of the [Officers of the Board](#) to accept for addition to the provisional agenda of the 146th session of the Board the item on Preventable blindness and impaired vision/vision for all, proposed by the Government of Indonesia, and the item on Integrated people-centred eye care – proposed by the Governments of Australia, Austria, Burkina Faso, Indonesia supported by the Member States of the South-East Asia Region, Mexico, Pakistan, Singapore and Tonga – merging them in a single standalone item.

Background

See [Tracker links](#) to earlier discussions of vision and eye care and [previous resolutions](#).

PHM Comment

The 2019 [WHO World report on vision](#) (on which [EB146/13](#) is based) is a useful and constructive document although shaky in some important respects.

The report provides an overview of the epidemiology of impaired vision globally and the principal modalities of prevention, treatment and rehabilitation and develops a case for 'integrated patient-centred eye care' or IPEC. IPEC is to be achieved through four strategies: (i) empowering and engaging people and communities; (ii) strengthening eye care in primary health care (PHC); (iii) coordinating services and programs within and across sectors; and (iv) creating an enabling environment.

PHM appreciates the vision of IPEC and endorses particularly the need for an 'enabling environment' including attention to health planning, workforce development and health information systems.

The report talks about empowering people and communities and about reorienting eye care within a primary health care approach. However, the service model which is projected is based more on a primary care perspective than comprehensive primary health care; indeed the term

'primary care' is used much more frequently in the report than 'primary health care'. The reorientation which is recommended includes outreach to the underserved and health education but there is nothing about structures to support family and community involvement in planning, program delivery or provider accountability. Comprehensive primary health care envisages health care practitioners working in partnership with families and communities to improve health services and outcomes.

PHM urges the Board to ensure that any resolution arising from this item highlights primary health care as an approach to health care delivery generally rather than restricting its meaning to primary care.

The silence of this report in relation to community involvement is in part a reflection of WHO's dogma around universal health coverage which privileges health insurance and mixed public private health care delivery. In accordance with this dogma the report speaks repeatedly about '*a package of eye care interventions*' but remains mute regarding the health system architecture through which such interventions are best provided.

On [page 74](#) of the report a box describes the English National Screening Programme for the early diagnosis and early treatment of diabetic retinopathy. This kind of large scale population based program depends on centralised coordination, powerful information systems, recall and follow up protocols all of which are more efficiently and effectively delivered through public sector organisation rather than the private sector.

PHM urges the Board to highlight the need for single payer funding and for progress towards comprehensive public sector provision in any resolutions arising from this item.

The report makes frequent reference to campaign style interventions (particularly in relation to cataract and trachoma) but does not consider the challenges of scaling-up such programs to ensure continuity and universal coverage. Integrating such programs into comprehensive and universal health care depends on strong public sector leadership and organisation.

The report highlights 'coordination' as one of the key pillars of the IPEC model; coordination between different specialties within the health sector and between health sector actors and those in education, labour, community services etc.

Coordinating services within and across sectors: coordination of care for the individual involves a range of strategies including case management, task-sharing and efficient referral systems to improve the continuity of eye care, and a discrete, coherent and interconnected care process that meets individual needs and preferences.

The report is ambivalent in relation to the coordination of public and private sectors. While it recognises the risks of a dominant private sector including inequality in access to services and resistance to regulation it also urges the exploration of public private partnerships because of 'the growing demands for eye care'. This contradiction appears to be a reference to the myth of publicly subsidised private sector provision 'taking the pressure off' the public sector.

The report also fails to recognise the challenges of coordination and domestication where eye care programs are delivered in whole or in part through international development assistance (cataract, vitamin A supplementation, ivermectin, spectacles, trachoma).

In terms of advice to national planners the report finds difficulty in achieving a balance between vertical vision-specific program development versus integrated health system strengthening or between vision-specific interventions versus more broadly based health gain strategies (diabetes, nutrition, etc). Undoubtedly donor assisted vitamin A supplementation has impacted on the prevalence of child blindness. However, the efficacy of this intervention should not be allowed to defer action around the structural determinants of malnutrition generally. The report urges investment in screening for diabetic retinopathy but makes no reference to the cost barriers to insulin treatment in low income settings.

PHM urges the Board to ensure that any resolutions arising from this item keep the need for health systems strengthening generally uppermost.

13. Neglected tropical diseases

In focus

The current [NTDs road map](#) comes to an end in 2020. The Secretariat has commenced working on a new roadmap for the period 2021-2030.

[EB146/14](#) summarizes the current situation: what has been achieved; ongoing challenges; and opportunities. Under this last heading the report highlights new directions which should be reflected in the 2021-2030 global strategy.

The Board is invited to note the report and provide guidance on next steps. Presumably there will be a draft resolution adopted for forwarding to the Assembly to authorise the development of a new strategy.

Background

[Tracker links](#) to previous discussions of NTDs and vector control.

[Index page](#) to WHO's web pages on NTDs

[London Declaration on Neglected Tropical Diseases](#) (2012)

[WHO \(2012\). Accelerating work to overcome the global impact of neglected tropical diseases : a roadmap for implementation: executive summary.](#)

[WHO \(2015\) Water sanitation and hygiene for accelerating and sustaining progress on neglected tropical diseases: A global strategy 2015-2020](#)

[Neglected tropical diseases in the People's Republic of China: progress towards elimination. Infect Dis Poverty. 2019;8\(86\)](#)

[Evaluation of the WHO Neglected Tropical Diseases Programme \(2019\)](#)

[12th meeting of the Strategic and Technical Advisory Group for Neglected Tropical Diseases](#)

PHM Comment

Although brief, EB146/14 is a very useful document. It highlights the human and economic burden NTDs impose on those left furthest behind by development. It describes the progress that has been achieved over the last 9 years but is quite blunt in speaking of the 'challenges' facing the program. These include risks associated with conflict zones and refugee settlements, climate change, and an over-reliance on vertical programs and external partners. The report advises that "current approaches compromise the impact of interventions and lack coordination across the full scope of 20 diseases and beyond".

Under ‘opportunities’ the report highlights joint implementation of interventions, mainstreaming common delivery platforms (PHC in particular), intersectoral action, and “moving from disease-specific to integrated, patient-centred approaches driven by the needs of communities, in order to achieve greater impact”.

The report refers to the recent advice of the Strategic and Technical Group on NTDs, which in the [report of its 12th meeting](#) sets out recommendations for the new roadmap.

The recent corporate evaluation of the NTDs program ([executive summary here](#)) also sets out its recommendations for the new roadmap.

Strengths and weaknesses

Progress has been achieved. However, the program has relied heavily on vertical mass drug administration (MDA); progress with respect to multisectoral action (WASH, housing, education, employment, One Health) has been much less impressive. Progress has also been limited in relation to health system strengthening in particular in terms of primary health care and local public health leadership.

The ‘movement’ against NTDs has been strongly influenced by the ideologies of the ‘magic bullets’ and ‘cost-effectiveness’. Both MDA and CEA have a contribution to make but they should not be allowed to sideline the importance of multisectoral action, integrated control programs, PHC and health system strengthening, and political and economic reform.

The report by Dr Qian and colleagues on [NTDs in China](#) highlights the role of multisectoral action, primary health care, health system strengthening and economic reform in reducing the prevalence of NTDs in that country. In view of the size of China and the previous high prevalence it seems likely that in some degree the progress that is reported in EB146/14 reflects the impact of those broader measures.

Primary health care and health system strengthening

The contributions of comprehensive PHC to NTDs control are several. They include the provision of sick care for affected individuals and support for the delivery of preventive medications.

However, a strong PHC approach can contribute to developing the health literacy of affected communities; mobilising communities around vector control and transmission interruption, and promoting multisectoral action (eg WASH, food safety, food security, agriculture, school programs, etc).

In their rhetoric about universal health coverage, WHO and its partners, have endorsed mixed public private health care delivery. However, while private practice can deliver individual care it is not well placed to build the kinds of partnerships with other sectors and with communities which will be needed to build a comprehensive multi-pronged approach to NTDs.

PHM urges WHO to re-think its endorsement of mixed public private health care delivery in relation to UHC.

Health system strengthening for effective action on NTDs must also focus on local public health capacity and leadership. This will require a significant effort in terms of workforce development in many countries.

Multisectoral action and civil society engagement

The new roadmap must do more than pay lip service to the importance of WASH, food safety, food security, housing, employment, seasonal income fluctuations and agriculture. The roadmap must include robust strategies to drive such action. These will include research and information, liaison and advocacy, monitoring and accountability.

PHM urges WHO to recognise the role that civil society can play in driving such advocacy and accountability. PHM urges WHO at country and regional levels to reach out to civil society organisations and social movements in building a constituency for a truly comprehensive and integrated approach to NTDs.

Tracing the ‘causes of the causes’

While NTD program leaders have recognised the role of inequality and under-development in maintaining NTD prevalence, despite the SDH Commission report, WHO has yet to develop a systematic approach to the diseases of poverty and inequality, including malnutrition, in terms of recognising and addressing the ‘causes of the causes’.

PHM urges MS representatives to acknowledge how globalised capitalism, through liberalisation and austerity, is widening inequality and creating barriers to health and to social and economic development for those workers, farmers, regions and countries who are not well placed in global supply chains.

Notes of discussion at EB146

WHO needs to go beyond mass drug administration in addressing neglected tropical diseases (NTDs)

Multisectoral action (eg WASH, housing); health system strengthening (PHC and public health leadership); confront 'the causes of the causes'!

14. Global strategy and plan of action on public health, innovation and intellectual property

In focus

Report [EB146/15](#) presents progress in implementing decision [WHA71\(9\)](#) (2018). In [EB146/1 \(annotated\)](#) the Secretariat advised that:

In response to the request in decision [WHA71\(9\)](#) (2018), the Director-General will present a report ([EB146/15](#)) on progress made in implementing that decision. The report will review progress made by the Secretariat in implementing the recommendations of the overall programme review panel. The Board will be invited to note the report.

Decision [WHA71\(9\)](#) included four components, which the current report only partly addresses:

Para (1) urges MSs to implement the recommendations of the Review Panel which are addressed to MS ('as appropriate', 'taking into account national context').

Para (2) urges MSs to further discuss the 'recommendations not emanating from the GSPOA' but does not identify them. They are identified in footnote 1 on page 1 of [EB146/15](#) as Recommendations 4, 27 & 28 from the Review Panel Report which are listed, in [A71/13](#), as:

4. Member States to support the WHO Secretariat in promoting transparency in, and understanding of, the costs of research and development;
27. Member States to identify essential medicines that are at risk of being in short supply and mechanisms to avoid shortages, and disseminate related information accordingly; and
28. Member States to commit to dedicating at least 0.01% of their gross domestic product to basic and applied research relevant to the health needs of developing countries.

Para (3) requests the Director-General to implement the recommendations addressed to the Secretariat, as prioritized by the Review Panel, in an Implementation Plan, consistent with the GSPOA.

Para (4) requests a report on the implementation of the Decision.

[EB146/15](#) does not provide any information on paras (1) and (2) of Decision [WHA71\(9\)](#) which were addressed to MSs. **There is no provision for reporting, review or accountability regarding MSs' response to this 'urging'.**

Responding to para 3, [EB146/15](#) reports that a [draft Implementation Plan, 2020-2022](#) has been developed, which will be subject to further refinement, based on the results of a MS questionnaire and discussion at the Board.

Partially responding to para 4, [EB146/15](#) reviews progress made by the Secretariat in implementing the recommendations of the [overall programme review](#) (para 4 did not distinguish between recommendations addressed to MSs and those addressed to the Secretariat) and refers to the [draft Implementation Plan for 2010-22](#).

The Board is invited to note the report. In EB146/15 the Secretariat suggests that the discussion should focus on:

- The [draft Implementation Plan](#) for 2020-2022; and
- Discussions and actions since WHA71 (May 2018) regarding recommendations from the Review Panel “not emanating from the GSPOA”, viz Recs 4,27, & 28.

Note that this item was not on the original agenda, but [proposed by Brazil](#) and accepted by the Officers of the Board at their meeting in Manila in October.

There is too much detail in the draft Implementation Plan to allow for adequate discussion of all of the recommendations and actions during the Executive Board meeting. PHM urges further consultation, including civil society organisations, to allow fuller discussion of the proposed actions before WHA73.

Background

The GSPOA was adopted in 2008 to *promote new thinking on innovation and access to medicines and to secure an enhanced and sustainable basis for needs driven essential health research and development relevant to diseases that disproportionately affect developing countries*. (See [Tracker links to GSPOA](#), in particular WHA61 in 2008.)

See [Box 1](#) (from Overall Programme Review) for a summary of the elements of the GSPOA

An ‘Overall Program Review’ was appointed in 2015 and [reported](#) in 2017.

The Assembly’s most recent decision on GSPOA ([WHA71\(9\)](#) 2018) followed quite intense debate at EB142 (see [M7](#) and [M10](#)) over the recommendations of the expert panel for the Overall Program Review of the GSPOA (summarised in [EB142/14 Rev.1](#)) and the draft decision proposed by the Secretariat to “to take forward the recommendations of the review panel” ([EB142/14 Add.1](#)).

The underlying issues in contention (see [debate](#)) included WHO’s advocacy around implementing TRIPS flexibilities as a way of keeping prices down (which Japan said would reduce the incentive to invest in new medicines) and in promoting the transparency of R&D costs (which the US claimed would discourage pharma from investing in new drugs).

However, much of the debate focused on the legitimacy of some of the Review Panel’s recommendations, where some MS argued that some of the recommendations went “beyond

previous consensus” (EU and Switzerland), or were “beyond the scope of the GSPOA” (UK) or “beyond WHO’s mandate” (USA).

While the US repeatedly claims that the WHO’s engagement with TRIPS implementation issues goes beyond its mandate, this claim is baseless. Multiple resolutions have affirmed the WHO’s mandate to work on IP and trade (see for instance the WHO’s [background documents](#) on GSPOA).

The US and Switzerland [proposed](#) revising the draft decision in [EB142/14 Add.1](#) (supported by Japan), but strongly opposed by many countries (Brazil, Thailand, the Netherlands, Libya, Algeria (on behalf of the member states of the African Region), Sri Lanka, Pakistan, Vietnam, Colombia, the Dominican Republic, Burundi, the United Republic of Tanzania, Benin), who argued that delays to adopting the decision “could be construed as serving to protect the interests of the pharmaceutical industry.” Canada, France, Sweden and Italy proposed a drafting group restricted to ‘minor’ changes as a compromise.

While the drafting group reached a compromise, [leaks](#) from delegates participating in the drafting group (see ["Member states clash as WHO mulls ..."](#)) suggested that not everyone was happy with the revised decision, and that it was a pragmatic choice “so as not to risk losing the whole report altogether.” The revised decision ([EB142\(4\)](#)) distinguished between recommendations “emanating from the GSPOA” (which were to be implemented) and recommendations “not emanating from the GSPOA” (which were to be further discussed) and was adopted at WHA71 (2018) as ([WHA71\(9\)](#), see four main components, listed above).

In October 2019 the WHO Secretariat circulated a [questionnaire](#) for member states to inform the further development of the [draft Implementation Plan](#) and the implementation of related resolutions such as [WHA72.8](#) on medicines transparency.

See [Tracker links](#) to previous documents, debates and decisions on the GSPOA.

- For a prehistory of [GSPOA](#), see [PHM comment](#) on EB136 item 10.5 (2015), which discusses the origins and [report](#) of the 2006 Commission on IP, Innovation and Public Health and the subsequent debates which led to the GSPOA.
- For a fuller analysis of the Overall Program Review’s 2017 [report](#) (including its recommendations) and a comparison with the Secretariat’s 2016 [Comprehensive Evaluation](#) see [PHM comment](#) on [EB142 item 3.7](#) (2018).

See Secretariat index page for [Medicines: innovation, access and use](#).

See [Medicines and Intellectual Property: 10 Years of the WHO Global Strategy by Germán Velásquez](#), South Centre Research Paper 100, December 2019 for an insider perspective on the achievements and disappointments of the GSPOA.

Progress on implementation of WHA71(9)

The Overall Program Review's [report](#) set out 33 recommendations under 8 themes directed towards the WHO Secretariat, MS, and other stakeholders. Table 1 sets out who would be responsible for each recommendation, including supporting stakeholders.

Table 1: Overall Programme Review recommendations

Theme	Recommendation		WHO	MS	Other
Prioritize research and development needs	1	Sustainable financing		ø	
	2	Type I, II, III disease R&D needs	ø		
	3	Unmet needs	ø		ø Expert committee
Promote research and development	4	R&D Cost transparency		ø	
	5	Information sharing mechanism	ø		
	6	Clinical trial capacity		ø	
	7	Open access publication	ø	ø	
Build and improve research capacity	8	Research collaborations	ø	ø	
	9	Clinical trial oversight	ø		
	10	Training program database	ø	ø collaborate	
	11	Certified training courses		ø	

	12	Traditional medicines	ø support	ø	
Promote transfer of technology	13	SDG Technology Facilitation Mechanism	ø		
	14	TRIPS implementation	ø		ø WTO
	15	Collaborate with UN	ø		
Manage intellectual property to contribute to innovation and public health	16	Legislate TRIPS flexibilities	ø		
	17	Patent databases	ø		ø partner collaborate
	18	Medicines Patent Pool	ø support	ø	ø funders
	19	Trade agreements/TRIPS		ø	
Improve delivery and access	20	Good practice	ø		
	21	Guidance on price transparency	ø		
	22	Monitor out of pocket	ø	ø cooperate	ø partner cooperate
	23	Regulatory capacity	ø		
	24	Prequalification of Medicines Programme		ø	ø funders

	25	Best practices	ø		
	26	Procurement	ø		
	27	Medicine shortages		ø	
Promote sustainable financing mechanisms	28	Financing		ø	
	29	Domestic resource mobilisation		ø	
	30	Delinking prices		ø	
	31	Diversified funding	ø support	ø	
Establish a monitoring and accountability mechanism	32	Implementation plan	ø		
	33	MS info		ø	

The [draft Implementation Plan](#) (responding to para (3) of decision [WHA71\(9\)](#)) outlines the actions the WHO Secretariat is taking in response to recommendations directed towards it (2, 3, 5, 7-10, 12-18, 20-23, 25, 26, 31, 32). And in accordance with para 4 of WHA71(9) reports on progress in implementation. Many of the proposed actions involve expanding on initiatives currently in place, including the Global Observatory, WHO's Open Access Policy and various activities directed to capacity building, technology transfer, intellectual property, procurement, availability and affordability and monitoring.

[EB146/15](#) describes a range of structures and activities in which the Secretariat has been involved which have in various ways responded to the recommendations of the Review Panel. In several cases the proposed actions do not respond fully to the recommendations of the Review Panel or have been significantly weakened, for example:

Rec 7 (MSs and the Secretariat to encourage funders of R&D to require and support open access publication) appears to be incomplete. The report describes the initiatives taken by WHO itself but **there are no data in the report regarding any actions by MSs to encourage other funders of R&D in this respect.**

Rec 8 (that the Secretariat and MSs promote capacity building through research collaborations) the report cites the R&D blueprint for high priority pathogens, the ongoing work of Tropical Diseases Special Programme and work in the area of traditional and complementary medicine. **These do not constitute a comprehensive response to the recommendation.**

A full analysis of the implementation plan and the EB146/15 report is beyond the scope of this commentary. Please see [Annex](#) for details on the implementation of WHA71(9), including commentary on strengths and weakness and areas where actions are lacking.

PHM Comment

There is too much detail in the draft Implementation Plan to allow for adequate discussion of all the recommendations and actions during the Executive Board meeting.

- **PHM urges further consultation, including civil society organisations, to allow fuller discussion of the proposed actions before WHA73.**

Further, it is unfortunate that there is virtually no information provided in EB146/15 regarding any progress on the recommendations which were largely addressed to MSs. The report provides no information regarding discussions among MSs regarding the recommendations of the Review Panel identified as 'not emanating from the GSPOA'. In accordance with WHA71(9) the draft Implementation Plan only considers those recommendations of the Review Panel which were addressed to the Secretariat. There appears to be no proposal for monitoring or accountability regarding those which were addressed to the MSs, which are logical, evidence based and directed to overcoming barriers to access.

- **PHM urges the WHO/MS to develop a similar implementation plan to monitor MS progress.**

The original mandate for the GSPOA expires in 2022 as would the authority of the proposed Draft Implementation Plan. The Board may consider options for a longer term commitment to implementing the original program of the [Commission on Public Health, Innovation and Intellectual Property](#).

- **PHM urges MSs to request the Secretariat to develop a new mandate to authorise WHO's continued work across all eight of the elements of the GSPOA.**

The real reasons for implementation failure

The main barrier to the full implementation of the GSPOA arises from the contradiction between the public health objectives of WHO and the determination of the pharmaceutical industry to maintain maximum freedom of action in the pursuit of profit. This contradiction influences all of the elements of the GSPOA (see [Annex](#) for further details).

For example, the Review Panel calls for a capacity to promote research and development and amongst the requirements for this identifies transparency regarding the costs of R&D. Pharma price setting both for government procurement and open market sales has been defended on the basis of outrageous claims regarding the cost of R&D.

The ‘transparency debate’ at WHA72 also highlighted the ways in which countries with strong monopsonic negotiating positions in price setting (UK and Germany in particular) were opposed to price transparency because it would reveal those advantageous deals.

Exaggerated claims regarding the costs of R&D are used to justify high prices, even in markets with many poor people without social protection. While affordability is not the only barrier in accessing medicine, it is a significant one (up to [90 percent](#) of the population in developing countries pay out of pocket). Pharma greatly inflates the costs of R&D in order to justify hyper profits much of which go into aggressive marketing including driving over use (and inappropriate use) and thereby further increasing profits. Pharma also uses marketing to promote the message that IP-fosters innovation.

While R&D priorities are determined by profit expectations a range of populations and needs are neglected (antibiotic development, epidemic pathogens, neglected tropical diseases).

The head butting between public health and Pharma will go on, and unless the power relations across WHO decision making are changed, implementation will remain stalled.

Pharma’s power to influence WHO decision making is largely indirect; mediated by bilateral donors (in particular, the US, UK, EU and Japan), multilateral donors (especially the World Bank) and philanthropic donors (including in particular the Gates Foundation). In the case of the bilateral donors the defense of Pharma arises from its influence at home, including export revenues, taxation, and election funding. In the case of the multilaterals and the philanthropists it arises from a more ideological commitment to ‘free market’ monopoly capitalism.

Undoubtedly the message is made clear to the Secretariat, in the course of funds mobilisation and in regular contacts, that over-enthusiastic prosecution of the access to medicines objective to the detriment of Pharma profits would have serious implications for the WHO budget. More directly the donors maintain sharp conditions on their contributions and refuse to support A2M activities.

The Implementation Plan notes in para 13 that a “necessary condition for success is adequate, sustainable funding by Member States, including for activities that are the responsibility of

WHO". This is not currently provided. The WHO needs much greater budgetary discretion under the oversight of democratic decision making in the governing bodies.

- **PHM calls for funding reform: drop the freeze on assessed contributions and untie donor contributions. PHM urges MS to highlight the need for commitments to sustainable, adequate and untied funding mechanisms (especially from HICs), and to ensure that decisions over funding allocations are not captured by donors.**

NGOs, CSOs and social movements must redouble their efforts to build the civil society constituencies which can drive decision making for access to medicines. In the L&MICs this will involve ensuring that government officials are fully aware of the policy issues and the political interests. In the HICs this will involve exposing the role of governments in supporting Pharma profits at the expense of A2M.

15.1 The Independent Oversight and Advisory Committee for the WHO Health Emergencies Programme

In focus

[EB146/16](#) transmits the seventh report of the Independent Oversight and Advisory Committee (IOAC) for the WHO Health Emergencies Programme. The report conveys the Committee's observations and recommendations based on its review of WHO's work in major outbreaks and other health emergencies during the period May–December 2019.

Background

See the [IOAC index page](#).

See [Tracker links](#) to previous discussions of WHO Emergencies work and HEP including IOAC.

See PHM's [Updater Report](#) on this item following WHA72.

See WHO web page for the [IOAC for the WHO HEP](#)

[Special report \(2018\) of the IOAC \(HEP\) on diversity and staff morale](#)

The IOAC's [From “never again” to the “new normal”](#) report (2019) is a must read!

PHM Comment

The IOAC reports that “WHO has made a great deal of progress in outbreak management” which is gratifying. PHM appreciates the insights, analyses and recommendations offered by the IOAC. We highlight four specific issues arising from the IOAC reports.

Health system strengthening is a core component of preparedness

The IOAC reports progress in IHR capacity self-assessment, joint external evaluation (JEE), and country engagement with the National Action Plan for Health Security (NAPHS) process. See [NAPHS for all \(2018\)](#) and more about [NAPHS](#).

However, “the IOAC cautions that the impact of JEEs and NAPHS on strengthening International Health Regulations (2005) core capacities is still unclear.”

The [From “never again” to the “new normal”](#) (2019) report provides graphic evidence of why health system strengthening is a core component of preparedness planning. In this report the IOAC describes how a lack of attention to community engagement has limited the Ebola response in North Kivu and Ituri provinces in DRC. The IOAC finds that the role of community

engagement (“Ensure community engagement in outbreak response and health system strengthening”) is a ‘lesson not learned’ in the North Kivu and Ituri outbreak.

The Committee highlights the importance of a functioning primary health care system in working with communities to understand and work together to manage the emergency.

This is relevant to concerns expressed by some low and middle income countries that donor funding directed only to the development of IHR capacities risks further fragmentation if IHR capacity development were to proceed without integration into general public health and health care capacity.

PHM urges the IOAC to continue to give close attention to donor funding which places a disproportionate emphasis on the technical aspects of IHR capacities in both assessment and capacity building.

Emergency response in conflict situations

The [From “never again”](#) (2019) report also demonstrates how pre-existing conflict can complicate the emergency response. It is worth noting the Acknowledgement in that report:

Any assessment of the state of the Ebola response in North Kivu and Ituri must start with a recognition of the bravery and dedication of the individuals working for the Ministry of Health, Congolese civil societies, UN agencies, and non-governmental organizations in a complex and insecure operational environment.

Unfortunately

In [EB146/16](#) the IOAC refers to staff safety:

*The IOAC is deeply concerned about the security of Ebola response staff in the Democratic Republic of the Congo and urges all parties to step up their efforts to guarantee staff safety. The United Nations could do more to create an enabling environment, but **WHO should also continue strengthening capacity for its own security structures and ensuring robust internal security management.***

Beyond DRC the attacks on health workers and destruction of health care facilities has been a challenge in Syria, Iraq, Yemen and Libya. The reconstruction of health systems is a core component of emergency response. It would be useful to have the IOAC review WHO’s [Attacks on Health Care Initiative](#).

In [EB146/16](#) the IOAC also comments on the instance of corruption in Yemen (see also the [AP report](#) of 6 Aug 2019) and the challenges of risk assessment and risk management when operating in a conflict zone. The Committee recommends the strengthening of administrative capacity to reduce such risks.

PHM appreciates the assessments of the IOAC regarding the challenges of emergency preparedness and response in conflict situations. However, attention must also be paid to the causes of such conflict and the challenges of conflict prevention and peace building.

PHM calls on WHO to explicitly recognise the roots of conflict in widening inequality, climate change, food insecurity and geopolitical contests for markets and resources. Conflict is a public health issue, from war to domestic violence. WHO has a critical role to play in guiding health practitioners and agencies in understanding, preventing and working in conflict.

Empowering the WHO Representative and strengthening country offices

In [EB146/16](#) the IOAC recommends the strengthening of WHO country offices in several respects.

In the [From “never again”](#) report the IOAC recalls that:

In 2015, the Report of the Ebola Interim Assessment Panel recommended that WHO adopt a new approach to staffing in country offices, noting that “the country circumstances must be taken more fully into account, and the highest level of capacity must be ensured for the most vulnerable countries. At country level, the WHO Representative must have an independent voice and be assured of the full support of the Regional Director and the Director-General, if challenged by governments.”

The Committee concludes that “this remains an urgent priority, and is a prerequisite to building the institutional relationships between WHO and humanitarian partners at national level that can be called on during emergencies”.

PHM supports this recommendation.

Lift the freeze; untie donor funding

The IOAC repeatedly comes back to lack of funding for the WHO Health Emergencies (WHE) and its dependence on a wide range of disparate donors. Speaking about the need to replenish the Contingency Fund for Emergencies (CFE), the IOAC notes that it “was briefed that the revised replenishment strategy would be complemented by a road map showing how to better position, or reposition, the CFE in consultations with donors.”

The committee comments on the low investment in Ebola preparedness. As of 4 December 2019, WHO had received only US\$ 7.45 million of the total funding requirement US\$ 66 million as set out in the [SRP Ebola Congo July-December 2019](#).

The transaction costs, of ‘better positioning with donors’, are huge; at all levels and in all aspects of preparedness and response. The effectiveness and efficiency of the WHE programme will remain limited unless the freeze on assessed contributions is lifted.

Lift the freeze; untie donor funding.

15.2 WHO's work in health emergencies

In focus

Pursuant to requests in resolution [EBSS3.R1](#) (2015) and decision [WHA68\(10\)](#) (2014), this report ([EB146/17](#)) provides:

- an update on all Public Health Emergencies of International Concern, WHO Grade 3 and United Nations InterAgency Standing Committee Level 3 emergencies in which WHO took action in 2019 (up to October);
- a description of the work WHO is undertaking at global, regional and country levels to prepare for, prevent, detect and respond to health emergencies, including WHO's role as health cluster lead; and
- an update on the progress made to improve research and development for potentially epidemic diseases.

Note the decision of the [Officers of the Board](#) to include within this item reports requested by Iraq on health system rehabilitation after crisis, and by Russia on WHO's role as the health cluster lead in humanitarian emergencies.

The Board is invited to note the report.

Background

WHO's [Emergencies index page](#).

See [Tracker links](#) to previous discussions of WHO Emergencies work and HEP.

PHM Comment

The need for emergency preparedness, response and recovery is huge. The humanitarian crises described in [EB146/17](#) are dreadful. PHM appreciates the work of the Emergencies Programme and WHO staff everywhere who contribute to its work.

In particular PHM appreciates the contribution of [Dr Peter Salama](#) as the inaugural Director of WHO's Emergency Program.

Health security preparedness

EB146/17 (paras 20-22) discusses progress in IHR capacity assessment but provides no information about financial assistance to LMICs to build their IHR capacities.

There are no references in EB146/17 to the [Global Strategic Plan](#) to Improve Public Health Preparedness and Response, 2018–2023 adopted in May 2018 in [WHA71\(15\)](#). PHM welcomed the adoption of this plan, in part because of the commitments under Pillar 1: Building and

maintaining States Parties' core capacities required under the International Health Regulations (2005):

- to prioritize the Secretariat's provision of support to high-vulnerability, low-capacity countries;
- to mobilize financial resources to facilitate the implementation of the Regulations at the global, regional and national levels;
- to link the building of core capacities under the Regulations with health systems strengthening.

It appears that the Secretariat has judged that the obligation (under [WHA71\(15\)](#) to report annually is met through the reports of the WB & WHO sponsored [Global Preparedness Monitoring Board](#). This would be unfortunate as the 2019 report of the GPMB does not report on the commitments under Pillar 1 of WHA71(15).

PHM notes the strong emphasis on global security in the report of the GPMB. Likewise the IOAC reports (in [para 41](#)) that "a draft framework on leveraging health systems for health security ... [has] been put in place". It is not clear what this is supposed to mean nor where it might be found.

This discourse of securitisation is a double edged sword (see [GHW chapter](#)). When health is framed as a security issue, rather than a human rights issue, this may generate greater political interest and financial resources. However, it also risks pathologising affected populations (as the threatening 'other') and promoting vertical interventions that are uncoupled from efforts to promote health systems strengthening, and more broadly, improvements in the social determinants of health.

It is useful to consider the costs of IHR core capacities in terms of opportunity costs, the benefits which could be achieved from alternative uses of those resources. For countries with weak health systems the opportunity costs of investing in IHR capacities may be very high in terms of funds not going to reproductive health care (and reducing maternal mortality) or not going into immunisation (and improving child health).

By contrast the benefits, in terms of strengthened global health security, which come from achieving core capacities in L&MICs are shared across other countries and peoples, including those rich countries who refuse to invest in building WHO's emergency response capacity and the contingency fund. The costs of global health security (both national IHR capacity and global emergency capacity) should be equitably shared in a spirit of solidarity.

In adopting the Global Strategy the Assembly committed the Secretariat to produce a "Conceptual framework for harmonizing the core capacities requirements under the Regulations with national health systems and essential public health functions [to be] developed by May 2018". If this has been produced it has certainly not been flagged for the attention of the Board.

Preventing epidemics and pandemics

EB146/17 (paras 23-25) deals with prevention. This is a useful section but entirely focused on the technical challenges of preventing of epidemics and pandemics.

The challenge of prevention goes much further. Para 6 of EB146/17 notes the constraints that impacted WHO's emergency responses during 2019. These included: "the scale and magnitude of simultaneously occurring crises, accompanied by mass population movements; ongoing insecurity; limited humanitarian access; lack of sufficient funding to ensure sustainable and continuous life-saving health services to crisis-affected and vulnerable populations; limited human resources capacities; looting; attacks on health care workers and facilities; and escalating field costs".

The WHE Programme's work takes place in the context of ongoing war and conflict in much of Africa and the Middle East, and the increasing frequency of extreme weather events. Many of these emergencies arise as a consequence of geopolitical crimes, economic injustices (corruption, tax evasion, unfair trade rules, etc) and climate denialism.

However, the reports on this agenda item do not acknowledge the importance of addressing these broader social determinants of health in order to prevent health emergencies at source. The public health principle of understanding upstream determinants should apply in relation to health emergencies.

Of course, the prevention of geopolitical crimes, economic corruption and climate change denialism are multisectoral and WHO has few levers for unilateral action. However, as a humanitarian agency operating in crisis situations, WHO should be documenting these links.

Health system recovery after crises

EB146/17 does not appear to address the issue of rehabilitation of the health system after crisis raised by Iraq, notwithstanding the decision of the [Officers of the Board](#). Clearly the Secretariat didn't have enough time to prepare a substantive report around this issue between October and December.

In para 41 of [EB146/16](#) the IOAC refers to health system strengthening in Iraq but provides no detail. The 2016 report on [Iraq Humanitarian Response Plan](#) refers to 'support and recovery of existing health-care system in crisis-affected areas' but provides no detail.

The IOAC (in EB146/16) acknowledges the need to strengthen health systems as an integral part of emergency responses. However, it remains agnostic about whether this is done through strengthening private or public health care providers. When health systems strengthening and UHC are promoted through an expanded role for the private sector, the commodification of health care services that is central to this approach often results in limited access to care for the poor and marginalised.

PHM [comment, on Item 7.1 on UHC](#), argues that WHO has deliberately avoided producing an honest, evidence based account of health care financing option including the risks of mixed health service delivery because of the sensitivity of some of its donors.

Funding for WHE Programme

Funding for WHE Programme work remains unpredictable and precarious, despite the proven efficacy of this programme. See paras 34 and 35 of the IOAC report ([EB146/16](#)) for details of the shortfalls in the funding and replenishment of the Programme and the Contingencies Fund

PHM urges MS to commit to fully funding the Emergency Programme and maintaining the CFE at secure levels through voluntary core contributions. WHO's operational capacity in this important area should not remain dependent on the vagaries of tightly tied voluntary donor funding.

In the long run MSs must lift the freeze on assessed contributions and untie their voluntary contributions.

15.3 Influenza Preparedness

In focus

[EB146/18](#) reports on:

- the development and launch of the new [Global Influenza Strategy 2019–2030](#), including recent work of the Global Influenza Programme and the Global Influenza Surveillance and Response System towards stronger preparedness, and
- actions taken to implement decision [WHA72\(12\)](#) including the requests:

The Board will be invited to note the report and provide guidance in specific areas; the Secretariat suggests a focus on:

- suggestions for further sensitizing Member States to the importance of timely influenza virus sharing;
- ways to promote influenza prevention and control strategies, including through the use of seasonal vaccination.

Note the decision of the [Officers of the Board](#) to accept the request from the Governments of United States of America and Brazil that the title of this item be changed from “PIP Framework” to “Influenza Preparedness.”

Background

See [PHM comment](#) prior to WHA72.

See [Tracker links](#) to previous discussions of PIP and Nagoya

See WHO's [PIP index page](#)

See [Global Influenza Surveillance and Response System \(GISRS\)](#)

Consultation (June 2019) on influenza product research and innovation: [consultation report](#) and [package of tools](#).

See [Secretariat presentation](#) prepared for 7 Oct Information Webinar on the implementation of WHA72(12)

PHM Comment

Virus sharing

WHA72(12) asked the DG to report on the implications for public health of virus sharing under the Global Influenza Surveillance and Response System (GISRS), including obstacles to influenza virus sharing.

Four instances are reported of delays in the sharing of seasonal influenza viruses due to restrictions which may have been imposed by national legislation, in three cases associated with the Nagoya Protocol. The Secretariat proposes further research and analysis.

Legislation and regulation

WHA72(12) asked the DG to report on the treatment of influenza virus sharing and public health by existing relevant legislation and regulatory measures, including those implementing the Nagoya Protocol.

The Secretariat is working on this request.

Search engine

WHA72(12) asked the DG to provide more information on the functioning, usefulness and limitations of the prototype search engine.

Work is planned on this request.

Databases and initiatives

WHA72(12) asked the DG to explore next steps in raising awareness of the PIP Framework among relevant databases and initiatives, data providers and data users, and in promoting the acknowledgment of sources by data providers and collaboration between data providers and data users

Work is planned, directed to “promoting acknowledgment of data providers and collaboration between data providers and data users”. This stops well short of declaring genetic sequence data (GSD) to be biological materials in the terms of the PIP Framework which had been recommended by the [2016 PIP Framework Review](#) (see Rec 12). In May 2019 at WHA72 (see [PSRA9](#)) the USA spoke against recognising GSD as a biological material. Indonesia, Brazil and Thailand spoke in favour. Namibia, Iran, and Mexico urged further deliberation.

If benefit sharing obligations are not extended to users of genetic sequence data the principle of linking benefit sharing to the provision of samples will be progressively vitiated.

New developments

WHA72(12) asked the DG to continue providing information on new challenges posed and opportunities provided by new technologies in the context of the Pandemic Influenza Preparedness Framework for the sharing of influenza viruses and access to vaccines and other benefits and possible approaches to them.

In responding to this request the Secretariat mentions the [June 2019 technical consultation \(qv\)](#) and an internal seminar on a universal influenza vaccine.

Core principles

PHM urges the Board to:

- affirm access and benefit sharing (ABS) as core principles to guide global policy making regarding communicable disease preparedness;
- support the inclusion of GSD under ‘biological materials’ in PIP; and

- insist that the use of GSD is conditional on benefit sharing.

We do not favour inclusion of seasonal influenza or other pathogens under PIP.

Ministries of Health must be closely involved in domestic and international debates around communicable diseases preparedness:

- arguing for the importance of ABS regarding all pathogens (IPP, seasonal influenza, emergency and other); and
- arguing for GSD to be encompassed in such ABS.

15.4 The public health implications of implementation of the Nagoya Protocol

In focus

[EB146/19](#) provides an update on the Secretariat's work to implement decision [WHA72\(13\)](#) (2019), which asked the DG to collect information and prepare a report on: current pathogen-sharing practices and arrangements, the implementation of access and benefit-sharing (ABS) measures, and the potential public health outcomes and other implications. It envisaged a definitive report for WHA74 with an interim report to be considered at EB146.

The Board is invited to note the report and consider the proposed next steps for implementing decision [WHA72\(13\)](#). Work to date includes stakeholder consultations, analysis of data from the NP ABS clearing house, and the development of a survey to collect information across the three domains. [The survey](#) is now open for participation by all MS and is anticipated to close on the 31st January 2020 (See [Survey page](#) on WHO website and [list of survey questions](#).) The leading questions informing the survey design concerned alleged delays and high transaction costs associated with the bilateral nature of ABS provisions under the Nagoya Protocol (NP).

Background

The Nagoya Protocol (NP) first emerged as an issue for the WHO in 2015 in relation to its implications for the Pandemic Influenza Preparedness (PIP) Framework. In 2019 it became a separate agenda item, however controversies over Access and Benefit Sharing (ABS), the status of Genetic Sequence Data (GSD) and governance arrangements continue to dominate debates over both items.

- See [Tracker links](#) to previous discussions of the Nagoya Protocol.
- See [WHO's Fact Sheet](#) about the NP (of March 2018).
- See in particular the TWN report of 11 June 2019 '[Nagoya Protocol Decision Asks WHO to Report on Current Pathogen-Sharing Modalities](#)'.

Below is a brief history of the WHO's considerations of the NP.

2015: NP becomes an issue for the WHO

The Nagoya Protocol (NP) emerged as an issue for the WHO in the [report for 2014](#) of the PIP Framework Advisory Group (PIP AG).

It was considered further in a special meeting of the PIP AG (Oct 2015) in the context of planning for the PIP Review ([EB138/21 Add.1](#)). The AG discussed possible synergies between the IHRs and other international instruments including the NP and recommended to the DG that the PIP review should pay particular attention to "Linkages with other instruments (the Global Action Plan, International Health Regulations (2005), Nagoya Protocol, etc.)".

2016: WHO explores the health implications of NP

In Jan 2016 the AG's recommendations (in [EB138/21 Add.1](#)) were discussed at EB138 under Item 8.2 concerning PIP. In [debate](#), Japan, South Korea, and Canada supported the AG proposals for the Secretariat to explore the broader public health implications of the implementation of the Nagoya Protocol.

Nagoya was also considered at EB138 under Item 8.1 considering the first [report of the review Committee](#) on the IHRs in the 2014 Ebola outbreak. In [debate](#) UK and Finland expressed concern about ABS arrangements under NP affecting pathogen sharing.

Following the discussion at EB138, the Secretariat undertook a more detailed study of the NP ([report](#) here) exploring three questions: 1. How the Nagoya Protocol might affect the sharing of pathogens, including both seasonal and pandemic influenza; 2. The potential public health implications of this sharing, and; 3. Possible options for advancing public health, supporting the objective of a fair and equitable sharing of benefits.

2017: Can PIP be exempt from the Nagoya Protocol (NP) as a 'specialised international instrument' (SII)?

At EB140 (Jan 2017) NP was considered again under two items. Under Item 7.4 the Board considered the Secretariat report on the public health implications of the NP ([EB140/15](#)). Under Item 7.5 the Board considered the report of the PIP Review Group (in [EB140/16](#)), which recommended that the PIP Framework should be considered as a Specialized International Instrument (SII) under the NP

These two reports were considered conjointly by the Board ([debate here](#)). While there was agreement from many states (Liberia, NZ, Canada, Thailand, Finland, Monaco, Brazil and Australia) and also IFPMA that PIP should be considered an SII under the NP, the US and Japan were not enthusiastic.

At WHA70, under Item 12.5 (PIP) the Assembly considered the Secretariat report ([EB14/15](#)) on the public health implications of the NP and also a report from the Secretariat ([A70/57](#)) regarding discussions between the Secretariats of WHO and the CBD.

Several questions emerged more clearly from this discussion ([PSRA6](#)):

- What are the processes for determining that an alternative ABS arrangement (specifically, the PIP Framework) might be recognised as a specialised international instrument (SII) under the NP?
- What are the implications of including or not including GSD under PIP (see [PHM comment on EB140](#))?
- If PIP were exempted from the NP (as a SII), and GSD were **not** included under PIP, would ABS regarding PIP GSD be regulated under the NP?

- What is the status of polio virus sharing (under the Global Polio Laboratory Network) and the sharing of seasonal influenza samples under the Global Influenza Surveillance and Response System (GISRS)?

The US, Russia, Norway, Lesotho, Germany, Switzerland and Botswana, and the IFPMA expressed caution about the expansion of the PIP Framework and asked for more research and consultation. Most countries supported further study and consultations with the CBD.

The Assembly decided in WHA70(10) to request the DG to conduct a thorough and deliberative analysis of the issues raised by the Review Group's recommendations on seasonal influenza and genetic sequence data (GSD), including the implications of pursuing or not pursuing possible approaches.

In Oct 2017 the Secretariat published a detailed [scoping paper](#) (scoping what might be included in the Analysis requested in WHA70(10)) which weighed up the pros and cons of three approaches: 1) do not expand PIP (meaning the NP ABS regime could apply to GSD or other pathogens); 2) expand PIP to include seasonal influenza and/or GSD; or 3) create/modify a separate ABS mechanism (for seasonal influenza and other pathogens) that is also recognised as an SII.

2018: Further study and analysis

The NP was not discussed at EB142 (Jan 2018). Meanwhile WHO and CBD continued their collaboration, resulting in a [Q&A document](#), [draft report](#), [workshop](#) and [stakeholder consultation](#). The CBD was also conducting its own consideration of the management of GSD, criteria and processes for recognising SIIs, and the scope for creating multilateral processes for ABS under the NP (see below).

In 2018, under the aegis of the WHO R&D Blueprint (an initiative under WHO's emergency mandate) the Secretariat developed a draft '[code of conduct](#) for open and timely sharing of pathogen genetic sequence data during outbreaks of infectious disease'.

2019: NP and PIP are separated

At [EB144/23](#), the DG proposed (following the advice of the PIP AG) that PIP should be separated (in terms of agenda items at governing bodies) from "broader discussion of access and benefit sharing for a wider set of pathogens". This was agreed to although not without controversy (see [debate](#) at EB144). The controversy focused on allegations that the PIP AG had gone beyond its mandate (in straying beyond PIP) and the DG had gone beyond his mandate (in including NP as a separate item on the provisional agenda for WHA72).

Nevertheless, the NP appeared as a separate item at WHA72 and in [A72/32](#) the DG proposed an ambitious project to analyse the best practice in ABS for pathogens. The DG's proposal explicitly supported the NP and sought to "explore, in close dialogue and collaboration with all relevant partners, possible options, including codes of conduct, guidelines and best practices,

and global multilateral mechanisms, for pathogen access and benefit sharing. Such work would be done in harmony with the Nagoya Protocol and its principles....”. Presumably this initiative would have included progressing the code of conduct for GSD access and equitable benefit sharing.

Several countries and other stakeholders were unhappy with the positive tone about the NP (see [GISAID criticism](#): “The access and benefit sharing principles of the CBD and NP should not incentivize countries to restrict access to their pathogen samples in order to leverage a financial benefit from their use”). The DG’s proposal was eventually reduced to a survey on pathogen sharing.

A draft decision was proposed by Finland ([A72/1/CONF./3](#)) and in [debate](#) India proposed several counter-amendments. India was successful in removing a reference to “associated economic impacts” but was unsuccessful in respect of other amendments including ‘reaffirming’ the CBD rather than ‘taking note of’ (which ended up as ‘recalling’) and removing the reference to ‘broadening engagement ...’ (opposed by USA, Switzerland and Romania (on behalf of the EU). Out of this discussion the Assembly adopted [WHA72\(13\)](#) (‘The public health implications of the Nagoya Protocol’) which commissioned the Secretariat to “broaden engagement with Member States, the Secretariat of the Convention on Biological Diversity, relevant international organizations and relevant stakeholders: (1) to provide information on current pathogen-sharing practices and arrangements, the implementation of access and benefit-sharing measures, as well as the potential public health outcomes and other implications; and (2) to provide a report to the Seventy-fourth World Health Assembly, through the Executive Board at its 148th session, as well as an interim report to the Executive Board at its 146th session.

The issue of delays under the NP was further developed under WHA72 agenda item 12.1 on the PIP Framework. Under this item the Assembly adopted [WHA72\(12\)](#) which mandated further investigation of delays experienced by the GISRS and MS experience of the NP. WHA72(12) also provided for modest progress in the investigation of the possible inclusion of GSD under PIP.

A [Secretariat presentation](#) prepared for the 1 Oct 2019 Information session on the implementation of WHA72(12) includes a very useful timeline document including both WHA72(12) and WHA72(13) and also the timelines of CBD decision making around digital sequence information (DSI / GSD) and SIIIs.

Discussions within the CBD

Recognition of SIIIs

In December 2016, the Parties to the CBD/Nagoya Protocol adopted a decision ([CBD/NP/MOP/DEC/2/5](#)) requesting the CBD secretariat to “conduct a study into criteria that could be used to identify what constitutes a specialized international access and benefit-sharing instrument, and what could be a possible process for recognizing such an instrument”.

The report of the subsequent study ([CBD/SBI/2/INF/17](#)), which was considered by the CBD's Subsidiary Body on Implementation in May 2018, identified three scenarios for recognition of specialised ABS agreements: "(1) recognition by the Nagoya Protocol COP/MOP; (2) recognition by other multilateral fora; or (3) recognition by a Party or group of Parties. These scenarios are not mutually exclusive, but represent possible real-life situations that could overlap and ideally complement each other."

The subsequent decision of the COP/MOP in Nov 2018 ([CBD/NP/MOP/DEC/3/14](#)) sets out a series of potential criteria but does not completely resolve the question.

Global multilateral benefit-sharing mechanism

Article 10 of the NP envisages a multilateral benefit-sharing mechanism but (as the [CBD website advises](#)) was included in the NP to address "issues that could not be resolved during the negotiation of the Protocol and for which further discussion was required". COP 11 in 2012 [commissioned](#) an expert group to advise on progressing this discussion. The expert group [reported in 2013](#) and in [2016](#). However, there remained significant disagreement within the CBD regarding the best way to proceed (see the unresolved issues in [decision](#) of the 2018 meeting of the Subsidiary Body on Implementation). The square brackets were removed in the Nov 2018 [decision of the COP/MOP of the NP](#) which however was largely about collecting more information and undertaking further consultations.

PHM Comment

Much of the debate within WHO regarding the NP has essentially been whether pathogen sharing under WHO's auspices should adapt to the principles and arrangements of the NP or should be kept 'in house' through mechanisms such as the PIP Framework (and perhaps the Global Polio Laboratory Network and the Global Influenza Surveillance and Response System (GISRS)), which could be recognised as specialised international instruments (SIIs) in accordance with the NP.

In [A72/32](#) the secretariat proposed to explore: working in harmony with the Nagoya Protocol and its principles; and exploring all possible options for pathogen access and benefit sharing, including codes of conduct, guidelines and best practices, and global multilateral mechanisms. This program was not supported at WHA72.

In policy terms the chief argument has been about the risk of delays in accessing samples from human pathogens owing to the reliance of the NP on bilateral agreements. This argument continues to be prosecuted despite the provisions of Article 8(b) and the exploration by the CBD of multilateral arrangements.

It appears that some of the energy behind the delay argument are concerns that extending ABS to other human pathogens beyond pandemic influenza would impose additional costs, procedures and restrictions on vaccine manufacturers and associated networks of public health laboratories. It appears that the Pharma, with the support of the US and the EU, are seeking to

avoid linking benefit sharing to pathogen sharing (outside PIP); rather than negotiate the conditions under which access **and** benefit sharing are implemented.

However, the CBD is now in place; the NP is in place. Legislating for ABS is now a decision for sovereign states.

The survey

PHM urges all MS to participate in the survey (see [Survey page](#) on WHO website and [list of survey questions](#)). In particular, PHM urges MSs to consider the equity dimension of ABS in reporting their experiences with pathogen sharing. Likewise, where MSs are aware of delays in finalising ABS agreements under the NP, PHM urges them to consider whether it was due to the complexity of the bilateral arrangements or the unwillingness of commercial entities to offer equitable benefits.

Delays

With the entry into force of the NP comes the prospect of access and benefit sharing (ABS) mechanisms for a wide range of biological materials not previously subject to them (including seasonal influenza and epidemic pathogens) and for benefit sharing linked to GSD access as well as biological samples.

The threat of delays in accessing biological materials and/or GSD, owing to the bilateral nature of the NP arrangements, is being used as an argument for caution in terms of WHO's relationship with CBD (notwithstanding Article 8(b) regarding emergencies and the ongoing exploration, by the CBD, of multilateral mechanisms).

Article 8(b) of the NP reads:

In the development and implementation of its access and benefit-sharing legislation or regulatory requirements, each Party shall: ... (b) Pay due regard to cases of present or imminent emergencies that threaten or damage human, animal or plant health, as determined nationally or internationally. Parties may take into consideration the need for expeditious access to genetic resources and expeditious fair and equitable sharing of benefits arising out of the use of such genetic resources, including access to affordable treatments by those in need, especially in developing countries;

PHM urges MSs to work towards a set of arrangements that meld prompt sharing of pathogens and open source access to GSD with equitable sharing of benefits with source countries. Negotiating such arrangements will not be easy but they can be achieved.

Sharing of GSD

There has been significant push back against the inclusion of GSD within the PIP Framework and therefore the application of the principle of benefit sharing where such data are deployed for commercial gain. WHO's 2019 draft [Code of Conduct](#)'s provides for the full meeting of public

health objectives while recognising the equity of benefit sharing as well as the legitimate interests of data providers.

It would be unfortunate if a WHO refusal to include GSD within PIP led to countries using the NP to force ABS in relation to pandemic influenza GSD.

Special international instruments

It is not clear what the processes (both de jure and de facto) are, or should be, for determining that an alternative ABS arrangement (in particular, the PIP Framework) might be recognised as a specialised international instrument (SII) under the NP. Is it a decision of the COP/MOP of the CBD or does it lie with law makers designing national legislation for domesticating the NP?

Article 4 of the NP provides very loose guidelines. The report of the CBD study ([CBD/SBI/2/INF/17](#)), see above, confirm that the issue remains fluid. In the November 2019 multi-stakeholder [information session](#) on WHO's implementation of WHA72(13) WHO's legal counsel pointed out that the EU has already recognised the PIP Framework as a SII under NP. public health implications of the Nagoya Protocol and suggested that the recognition of PIP as a SII might be more a question of usage than formal determination. The session was recorded and can be either downloaded or streamed at the following links: [download](#) or [playback](#).

If WHO MSs do not wish day to day pathogen sharing to be subject to the mutually agreed terms and prior informed consent conditions of the NP they may need to restructure existing arrangements (such as polio virus sharing (under the Global Polio Laboratory Network) and the sharing of seasonal influenza samples under the Global Influenza Surveillance and Response System (GISRS)) so that they can be recognised as SIIs.

15.5 Cholera prevention and control

In focus

In May 2018, following the publication of the [Global Task Force Roadmap](#), WHA71 adopted [WHA71.4](#) on Cholera prevention and control. This resolution makes a number of recommendations for MSs and several requests of the DG including requesting a broad-ranging report for EB146.

[EB146/20](#) provides an update on the global cholera situation and progress in recent efforts made in cholera prevention and control. A more detailed update is provided in [WER 94\(48\), 961](#).

The Board is invited to note the report and to consider, in particular, surveillance and prompt reporting and full implementation of the prevention and control measures set out in WHA71.4.

Background

See WHO [Cholera page](#); note in particular the [OCV page](#)

See [Global Task Force on Cholera Control. Ending cholera: a global roadmap to 2030](#)

See [Tracker links](#) to previous discussions of Cholera prevention and control

PHM Comment

[WHA71.4](#) affirms that *“the prevention and control of cholera require a coordinated and multisectoral approach that includes access to appropriate health care, early case management, access to safe water, sanitation, education, health literacy and improved hygiene behaviours, with adjunct use of oral cholera vaccines, strengthened surveillance and information sharing, strengthened laboratory capacity and community involvement, including action on the social determinants of health”*.

It is apparent that many cholera-affected countries are not implementing in full the principles and practices urged upon them in [WHA71.4](#).

PHM urges the Executive Board to recommend to the Assembly strategies for strengthening the accountability of member states for fully implementing [WHA71.4](#), in particular through OP1(7), “to strengthen community involvement, social mobilization in cholera prevention, early detection, household water treatment and storage, and other related water, sanitation and hygiene response activities”.

Surveillance and reporting

EB146/20 claims a remarkable fall in cholera incidence and mortality globally associated with intensive vaccination efforts since 2017. Actually the reduced incidence and mortality are

achieved by removing from the totals the 370,000 cases and 500 deaths in Yemen in 2018 on the grounds that the data are 'imprecise'.

In fact one of the most positive aspects of the 2018 cholera data (see [WER 94\(48\), 961](#)) is the progressive reduction in case fatality rates from a peak of 5/100 cases in 1996 to the current global estimate of 0.6 per 100 cases. This presumably reflects better surveillance / early response and improved health care.

In its more detailed cholera report in [WER 94\(48\), 961](#) WHO notes that *"The epidemiological accounting is, however, skewed by the lack of full reporting from other high-burden countries in Asia. Bangladesh acknowledged cholera as a major public health threat by reporting cases to WHO in 2018 for the first time since 1997, although these were only confirmed cases from sentinel sites. India has continued its practice of reporting cases, primarily from West Bengal, but, again, only confirmed cases in a limited geographical area. In these 2 countries, however, with a total population of nearly 1.5 billion and heavily endemic for cholera, the true number of cases is understood to be substantially far higher."* India reported 697 cases in 2018 and no deaths. It seems likely that weak surveillance and reporting may well be associated with lower public health priority, delays in diagnosis and higher case fatality rates.

The Secretariat report on cholera in 2011 ([A64/18](#)) commented (in para 4) that "Underreporting may also occur because of concerns over possible sanctions on travel and trade. Sanctions have been shown not to contribute to the efficient control of cholera."

[WHA71.4](#) notes that "cholera, as a disease of epidemic potential, has to be recognized in itself and reported separately from other diarrhoeal diseases, within national surveillance systems, as not doing so hampers effective control measures".

EB146/20 comments (para 9) that: "Another promising development in 2018–2019 was the recognition that control or elimination of cholera requires governments to acknowledge and report the disease. Specifying cholera by name permits the introduction of a specific multisectoral control programme that targets the known risk factors and launches specific control measures." [WER 94\(48\), 961](#) refers to national reporting to WHO as a vital public health surveillance service, including "zero reporting".

WHO's cholera [key facts page](#) notes that: *"Countries affected by cholera are encouraged to strengthen disease surveillance and national preparedness to rapidly detect and respond to outbreaks. Under the International Health Regulations [2005], notification of all cases of cholera is no longer mandatory. However, public health events involving cholera must always be assessed against the criteria provided in the regulations to determine whether there is a need for official notification."*

WHA71.4 includes a para urging member states *"to refrain from implementing health measures that are more restrictive of international traffic and more invasive or intrusive to persons than reasonably available alternatives that would achieve the appropriate level of health protection, in line with the International Health Regulations (2005)"* [See [IHR \(2005\), Annex2.](#)].

Vaccination

It appears that early mass vaccination of outbreaks has contributed to the decline in cases and deaths observed in 2018 (excluding Yemen).

WHO's [cholera vaccines page](#) details the arrangements for accessing the Oral Cholera Vaccine (OCV) stockpile, including the seven criteria applied by the Global Taskforce OCV Working Group for accessing the stockpile.

EB146/20 comments that, "Oral cholera vaccine is just one tool in a large toolbox that includes sustainable water, sanitation and hygiene solutions, but it serves as a critical bridge to such longer-term efforts."

Water, sanitation and hygiene (WASH) infrastructure

EB146/20 does not report much progress in WASH infrastructure, despite its inclusion in the criteria for accessing the OCV stockpile.

A possible exception is a fund-raising project (reported in Para 12) sponsored by the International Federation of Red Cross and Red Crescent Societies, with the Islamic Development Bank, seeking to raise up to US\$ 150 million globally to support sustainable WASH projects in cholera hotspots in the most affected Member States of the Organization of Islamic Cooperation over the next 10 years.

However, generally progress is slow. WHO's [SDGs report for 2018](#) reports:

Unsafe drinking water, unsafe sanitation and lack of hygiene also remain important causes of death, with an estimated 870 000 associated deaths occurring in 2016. The WHO African Region suffered a disproportionate burden from such deaths, with a mortality rate four times the global rate. Available data from fewer than 100 countries indicate that safely managed drinking-water services - that is, located on premises, available when needed and free from contamination - were enjoyed by only 71% of the global population (5.2 billion people) in 2015, whereas safely managed sanitation services - with excreta safely disposed of in situ or treated off site - were available to only 39% of the global population (2.9 billion people).

One of the greatest challenges in most of the cholera burdened countries in sub-Saharan Africa is the government's inability to manage waste. Filth covers many portions of the major cities due to the high population densities in urban settlements which in turn is driven by the economic inequalities and climate variations that has made rural living a harsh reality. The high rural urban migration results in most large unplanned settlements without safe drinking water or provision for the disposal of faecal waste.

Economic denialism

[EB146/20](#) remarks that cholera "remains a global threat to public health and an indicator of inequity and lack of social development".

What is not mentioned is that economic inequality is increasing globally. Population displacement (through the impoverishment of small farmers, unemployment in cities and towns, xenophobia and global warming) is contributing to the growth of informal settlements without decent WASH infrastructure. Fiscal austerity (impacting on public infrastructure investment) is being imposed (or self-imposed) on more and more countries.

New technologies, such as improved diagnostics and new vaccines, can make a marginal difference but in the context of a global economic regime which drives inequality, austerity and displacement (neoliberal transnational capitalism) it is unlikely that cholera will be eliminated any time soon.

PHM calls upon EB members and other member state representatives to acknowledge the continuing disease burden of cholera as an indicator of the crisis of neoliberal globalisation. The roadmap for cholera control must contextualise the challenge of cholera in relation to this crisis.

If UNDP (see [HDR 2019](#)) is able to name elite power as a barrier to equity so should WHO!

17. Decade of Healthy Ageing

In focus

Pursuant to resolution [WHA69.3](#) (2016) in which the Global strategy and action plan on ageing and health, was adopted, a proposal for a Decade of Healthy Ageing 2020–2030 has been prepared with inputs from organizations in the United Nations system, international organizations and non-State actors.

The Director-General's report ([EB146/23](#)) summarizes the draft proposal, which extends the action plan to 2030 with strengthened multisectoral action and multistakeholder engagement. It details the vision, action areas, activities and their enablers, and sets out a framework to track progress.

The Board is invited to consider a draft decision (in [EB146/23](#)) which would endorse the Decade of healthy Ageing proposal and forward it to the Assembly for adoption.

Background

See [Tracker links](#) to recent discussions of Healthy Ageing

See [Global Strategy and Plan of Action on Ageing and Health](#) (Annex to A69/17)

See [World Report on Ageing and Health \(2015\)](#)

See [Political declaration and Madrid International Plan of Action on Ageing 2002](#).

See summary of [regional committee discussions in late 2019](#) of the global strategy and action plan on ageing and health.

PHM Comment

[WHA69.3](#) requested a number of actions from the Secretariat including a global campaign against ageism, a global status report on ageing, and a proposal for a Decade on Healthy Ageing 2020-2030.

[EB146/23](#) describes how the Secretariat has approached the proposal for a Decade of Healthy Ageing; provides a short summary of the proposal; and ends with a draft decision for the Board to consider, and forward to WHA73 in May 2020.

The proposed Decade would focus on four action areas that are intended to improve the lives of older people, their families and their communities:

- changing how we think, feel and act towards age and ageing;
- developing communities in ways that foster the abilities of older people;
- delivering person centred integrated care and primary health services responsive to older people; and

- providing older people who need it with access to long-term care.

The details of the proposed Decade are provided in the [full proposal](#).

PHM supports the proposed declaration of a Decade of Healthy Ageing and looks forward to its implementation. There is much in this proposal which PHM appreciates and warmly supports.

However, PHM has concerns regarding some aspects of the present draft proposal and urges MS to request the Secretariat to address these concerns before consideration by the Assembly.

Conceptualisation of ‘healthy ageing’

WHO’s usage of ‘healthy ageing’ is explained in the [World Report on Ageing and Health \(2015\)](#). This usage has a strong focus on ‘functional ability’ and ‘intrinsic capacity’.

PHM would like to see greater emphasis on the various ways in which older people can contribute to families, communities and society; a willing and appreciated contribution. The social contribution of older people is recognised in the Decade proposal but it is not explored in any depth.

Insofar as the Decade proposal treats older people as agents, capable of contributing (ideas, leadership, drive), it is as recipients of services, rather than citizens.

The social determinants of healthy ageing

The Decade proposal highlights wide inequalities in life expectancy which presumably correspond to differences in the quality of experience of ageing. The proposal suggests that healthy ageing can be understood as a function of the environments through which a person has lived.

Integral to these objectives and as a basis for creating sustainable, inclusive economic growth, is addressing the social determinants of healthy ageing, such as improving access to lifelong learning, removing barriers to retaining and hiring older workers and limiting the impact of job loss, providing adequate pensions and social assistance in financially sustainable ways and reducing inequality in care by better supporting informal caregivers. (S3.2 Decade)

This analysis is helpful as far as it goes but is a somewhat limited approach to the social determinants of healthy ageing. It fails to explore why the life trajectory of some groups does provide for continuing access to lifelong learning, continued secure (and rewarding) employment, adequate pensions and excellent care. And some groups have none of these. This analysis fails to confront the economic and political dynamics of inequality, poverty, lack of social protection, and austerity.

The recognition of wide diversity of ageing experience suggests we need a more nuanced approach to discussions about the social determinants of healthy ageing; having regard to the intersections of various identities.

The Decade proposal recognises ‘gender, ethnicity, level of education, civil status or where a person lives’ as ‘individual factors’ underlying inequities in the ageing experience but does not explore how these ‘individual factors’ are interrelated in shaping the ageing experience or how they compound or mitigate disadvantage.

The importance of comprehensive primary health care

PHM appreciates the references to primary health care in the Decade proposal. However, PHC is treated largely as the primary level of health services.

In [A72/12](#) (para 12) WHO defined primary health care is a ‘whole-of-society approach to health that aims to ensure the highest possible level of health and well-being and equitable distribution through action on three levels:

- meeting people’s health needs through comprehensive and integrated health services (promotive, protective, preventive, curative, rehabilitative and palliative) throughout the life course, prioritizing primary care and essential public health functions;
- systematically addressing the broader determinants of health (including social, economic and environmental factors, as well as individual characteristics and behaviour) through evidence-informed policies and actions across all sectors; and
- empowering individuals, families and communities to optimize their health as advocates for policies that promote and protect health and well-being, as co-developers of health and social services and as self-carers and caregivers.

This approach to health system development would be very well suited to addressing all of the barriers to healthy ageing identified in the Decade proposal, rather than simply understood as ‘primary health services’.

The Decade proposal emphasises repeatedly the need to mobilise community resources and good will in ‘campaigning to combat ageism’ ([WHA69.3](#)) but does not recognise the importance of supporting comprehensive primary health care in this project.

Long term care

PHM appreciates the emphasis in the Decade proposal on the need for decent affordable integrated long term care including the full range from community support to residential accommodation.

However, PHM is concerned about the reference to the WHO Secretariat designing “tools and guidance for a minimum package of long-term care” (p15 Decade). References to ‘minimum packages’ commonly refer to insurance benefits which is a highly inappropriate way to fund aged care.

Out of pocket expenses

In many countries health care expenditures are largely out-of-pocket which is a major barrier preventing older persons from accessing health care services. Indirect health supplies and medication costs further impact access to services for older persons, especially women. In addition, the availability and quality of mental health services are insufficient.

PHM supports the goals of universal availability of essential health services, free at the point of delivery. This should include quality services for older people including long term care

However, PHM condemns WHO's continued agnosticism regarding financing arrangements and health care delivery models. Notwithstanding the repeated references to private sector services in the Decade proposal, it is very hard for governments to ensure equity of access, quality of care and efficiency in private sector services. The lack of serious consideration of financing arrangements and service delivery models is a weakness.

The aged care cost panic

The Decade proposal refers to 'concerns' regarding escalating aged care and pensions as the ration of older to younger increases. The proposal argues, correctly, that the economic and social benefits of healthy ageing need to be set against the cost burden and identifies intergenerational solidarity as a core principle for the Decade.

However, the proposal fails to consider the 'cost burden panic' more deeply. The panic is closely associated with the low tax agenda; the drive for public sector austerity (self-administered structural adjustment); and the drivers of widening economic inequality.

Accountability

The Decade proposal is extremely weak in relation to accountability; in particular the accountability of private sector providers and government funders.

The proposal elevates 'measurement' to fetish level: "Governments, donors, civil society and other actors, including the private sector, increasingly recognize that what is measured drives action." (Decade proposal p 20). This faith in measurement appears to minimise the role of politics, economics and ideology in driving action.

This measurement fetish is associated with seriously weak 'indicators' (T7, Decade) which will measure the appearance of action rather than any substance.

The political economy of healthy ageing

The failure to address the political economy of (un)healthy ageing is a fundamental weakness of the Decade proposal.

The document does not enquire into the drivers of increasing un-, under-, and precarious employment and the significance of these drivers as barriers to healthy ageing.

The document does not enquire into the drivers of low tax, small government, austerity and the significance of these drivers in limiting the resource flows needed to support healthy ageing.

PHM urges MSs to request the Secretariat to revise the Decade proposal to as to more clearly identify the political economy barriers to healthy ageing and to provide leadership in removing those barriers.

Limited scope of research proposed

The discussion of research in the Decade proposal is overwhelmingly focused on research into service delivery; almost no references to researching the social determinants, including the intersecting influences of particular social factors in shaping inequalities in ageing outcomes and the political economy of healthy ageing.

18. Maternal, infant and young child nutrition

In focus

In response to the request in resolution [WHA71.9](#) (2018), [EB146/24](#) reports on progress with respect to the targets adopted in the [comprehensive implementation plan on maternal, infant and young child nutrition](#) (endorsed in [WHA65.6](#), 2012), and with respect to the five Actions adopted in the Plan.

It also provides an update on the implementation of the [International Code of Marketing of Breastmilk Substitutes](#) and WHO's recommendations on marketing of complementary foods ([WHA69.9](#)).

The Board is invited to provide guidance and consider a draft decision (on streamlining progress reports on a range of related issues).

This item appears as a consequence of [WHA71.9](#) (adopted May 2018) which recommended a number of initiatives to MSs and made several requests of the DG including that he report back to WHA73 in May 2020.

Background

The comprehensive implementation plan ([CIP](#)) on maternal, infant and young child nutrition was adopted in 2012 (in [WHA65.6 \(2012\)](#)). It includes six global targets and five action areas, in each case with activities for member states, the secretariat and international partners.

The Plan was conceived as covering a 13 year time frame, from 2012-2025, with biennial reporting. In [EB142\(6\)](#) the board decided to extend the Plan to 2030.

WHA71 (2018) reviewed Secretariat reports on the implementation of the CIP; on progress in implementing the Code of Marketing of Breastmilk Substitutes; on the implementation of WHO guidance on inappropriate promotion of foods for infants and young children (all in [A71/22](#)); and on safeguards against possible conflicts of interest in nutrition programs ([A71/23](#)).

The Assembly adopted [WHA71.9](#) which urged MSs and the Secretariat to try harder on all fronts.

Other resources:

- The [WHO/UNICEF Global targets tracking tool](#) provides access to basic outcome indicators (stunting, anaemia, low birthweight, overweight, exclusive breastfeeding and wasting) but doesn't include the various process and program environment indicators.
- The [Nutrition Landscape Information System \(NLIS\)](#) includes a wide array of indicators including some which are close to the core set adopted for the CIP.

- In [A69/7 Add.2](#) the Assembly was advised of the UN Decade of Action on Nutrition and in Resolution [WHA69.8](#) the Assembly reinforced much of what was already happening but in a new move invited member states to make 'SMART' commitments in accordance with the Rome Declaration emerging from the ICN2. See [A70/30](#) for an update on the Decade of Action.
- [GINA](#) (WHO's global database on the implementation of nutrition action) has a tab for 'commitments' and as of early Jan 2018 there were only two countries with commitments registered; by Late Jan 2020 this had grown to 3!
- See also [WHO-UNICEF Technical Expert Advisory Nov 2017](#) guidance on the Global Monitoring Framework for more detail on indicators;
- [Joint Child Malnutrition Estimates](#),
- The [State of Food Security and Nutrition in the World](#),
- and the [Global Nutrition Report](#).

See [Tracker links](#) to previous discussions relating to this item.

PHM Comment

Maternal, infant and young child comprehensive implementation plan

The targets adopted under the Comprehensive Implementation Plan (CIP) are not being achieved.

Many countries are dragging their feet.

PHM urges civil society actors at the national level to urge governments to fully implement their commitments under the CIP.

Malnutrition needs to be understood in terms of food systems, as well as specific nutritional deficiencies, and the reform of food systems calls for multisectoral action informed by an understanding of agriculture (including agroecology), food manufacturing (including ultraprocessed foods) and global trade. However, WHO's approach to intersectoral collaboration appears to deliberately avoid addressing the political economy of food systems.

PHM urges civil society actors at the national and global level to promote a political economy analysis of food systems as a necessary framework for policy development and implementation.

Shortfalls in relation to targets

[EB146/24](#) concludes (para 8) that:

Overall, only slow progress has been made in reducing stunting and low birth weight and increasing breastfeeding. Wasting and anaemia are still largely unaddressed, and overweight has continued to increase. This means that, in the absence of a substantial scale up in response actions, it is likely that the 2025 targets will not be met, and neither will the targets under Sustainable Development Goal 2, target 2.2 on ending all forms of malnutrition by 2030.

The report does not seek to understand or explain these significant shortfalls against the agreed targets.

EB146/24 describes a number of international nutrition initiatives, including several undertaken through the UN system. These kinds of high level declarative initiatives do not seem to be driving improvements in the global nutrition situation.

Countries dragging their feet

It is clear that many countries are dragging their feet on nutrition. EB146/24 refers to data from the [Global Nutrition Policy Review \(2016-17\)](#). Some salient findings from the latest policy review:

- 167 countries reported nutrition relevant policies, strategies and plans but only 39% of 149 countries with nutrition policies had costed operational plans associated with them;
- Countries that included relevant actions in their policies did not always implement those actions.
- Most countries included the global targets on child overweight (78%) and exclusive breastfeeding (71%) in their national policies. The largest gaps were in the WHO European Region (e.g. only 40% of countries in this region had policy goals on exclusive breastfeeding).
- Stunting was reported as being included in almost half of the 46 development plans reported; however, these plans often failed to address other global targets. Only a fifth of the 76 NCD policies reported had goals related to exclusive breastfeeding.
- Regulatory measures to protect breastfeeding, including the implementation and enforcement of the International Code of Marketing of Breastmilk Substitutes and the International Labour Organization Maternity Protection Convention, are largely inadequate.
- There has been a notable weakening in most school health and nutrition programmes since 2013.
- Only 18% of countries have a ban on vending machines in schools and only 24% have standards for regulating the marketing of foods and beverages in schools.
- Countries were more likely to implement educational programmes or disseminate information than to improve the food environment. Nutrition labelling and media campaigns were more often implemented than fiscal policies or regulation of marketing to children.

- Front-of-pack labelling systems and menu labelling were not commonly used in countries (with the exception of the WHO European Region).
- Only 43% of 143 countries had policies on reformulation (eg lowering free sugars in foods and drinks), 19% of 139 countries on banning trans-fatty acids, 30% of 142 countries on regulating marketing to children, 14% of 133 countries on portion-size control and 27% of 143 countries on fiscal policies.
- The most common taxation measure was taxation of sugar-sweetened beverages, but few countries were carefully defining the tax bases to induce a customer price preference that would encourage healthier behaviours.
- Most of the countries that were “on track” to meet the global targets (e.g. reducing stunting and anaemia, having high rates of exclusive breastfeeding and reducing levels of childhood obesity) had more relevant policy environments than countries that were “off track”. For example, countries that were on track to reach the exclusive breastfeeding goal more often had protocols for infant feeding in difficult situations and regulation of marketing of breastmilk substitutes.
- Although no countries were on track to reach the anaemia goal, those making some progress had fortified staple foods with iron more often than the countries that were not making any progress.
- Few Member States have policies (26%) and protocols (37%) that cover the nutritional needs of infants and young children during emergencies, despite the commitments made by Member States through the adoption of Health Assembly resolution WHA71.9 on infant and young child feeding.
- Nutrition interventions are often not part of benefit packages and when they are, their coverage tends to be insufficient: only one child in four with severe acute malnutrition receives adequate treatment.
- Of the 122 WHO Member States that include actions to address nutrition in schools in their national nutrition policies, the number planning to take measures to regulate the types of foods and beverages available in schools has fallen since the first Review, which was conducted in 2009–2010.
- Although 73 Member States are implementing excise or special sales taxes for sugar-sweetened beverages at the national level, many such tax laws still do not cover all relevant sugar-sweetened beverages systematically (often not including sweetened milk drinks or fruit juices). They also tax beverages with and without sugars at the same rate.
- Legal measures are being taken to limit quantities of industrially produced trans-fatty acids in foods in all settings in only 31 Member States.

WHO is to be appreciated for the effort that it is putting into trying to hold Member States accountable for implementing their policy commitments in high level declarations such as ICN2 and the SDGs. However, too many member states treat such commitments with disdain. The perceived irrelevance of high level declarations such as ICN2 is epitomised in the refusal of all but three of WHO’s member states to include any policy commitments on WHO’s [GINA database](#). It remains to be seen whether the new WHO/FAO Resource Guide [Strengthening Nutrition Action](#) makes a difference to this neglect.

Multisectoral action

The report cites two highly problematic publications in relation to multisectoral action around nutrition and avoids mentioning two others.

Acknowledging concerns over climate change and the ecological impact of food systems FAO and WHO held an international expert consultation on Sustainable and Healthy Diets in July 2019. The Consultation agreed on [guiding principles for what constitutes “Sustainable Healthy Diets”](#). The report of the consultation includes Summary Papers on ‘The role of healthy diets in creating environmentally sustainable food systems’, ‘The role of culture, economics and food environment in shaping choices for sustainable diets’, and ‘Territorial diets’. The focus of the guiding principles is on ecologically sustainable and healthy diets. It seems odd to exclude from such a consultation any substantive political economy analysis of global food systems.

The report cites the International Forum on Food Safety and Trade, which took place at WTO, Geneva, in April 2019 and includes the dubious assertion that “the substantial expansion of global trade means that consumers have access to a great quantity and diversity of food”. It is not credible that the Secretariat could be unaware of the downsides of the expansion of food trade including the impact of the ultraprocessed foods in countries with relatively low internal controls the consequential changing of dietary patterns and the emergence of NCDs.

In [our comment on Item 19 \(food safety\)](#) at this session of the Board we have pointed out the loss of sovereign control of national food systems associated with the liberalisation of global trade. We have argued that concerns regarding food safety should not be used not justify imposed upwards harmonisation of food standards which favours transnational food companies to the detriment of small scale producers and retailers.

Two recent report from the High Level Panel of Experts of the FAO Committee on World Food Security provide a different perspective. [HLPE 12](#) provides an overview of food systems, including a useful section on the political and economic drivers of food system change, including globalisation and trade. [HLPE14](#) provides an introduction to agroecological and other innovative approaches to sustainable agriculture and food systems. Neither of these documents is cited in EB146/24.

EB146/24 also ignores the work of the UN Human Rights Commission on the [right to food](#). Olivier De Schutter, the former special rapporteur on the right to food, has produced an overview of [the political economy of food systems](#). He discusses the development of food systems including health impacts and environmental impacts and the political economy of food systems reform. PHM urges member states to give full consideration to the political economy of food systems in reflecting on the failures of the Comprehensive Implementation Plan.

See [PHM comment on this item at WHA71](#) for a more extended comment on the need to address global food systems.

Resources for implementation

Reporting on Action 4 of the CIP ('Provide sufficient human and financial resources for the implementation of nutrition interventions'). EB146/24 cites a 2017 World Bank report on '[An investment framework for nutrition](#): Reaching the global targets for stunting, anemia, breastfeeding, and wasting'.

The Bank identifies six nutrition specific interventions which it proposes constitute an 'affordable package' to meet four nutrition targets (for stunting, anemia, breastfeeding, and wasting). The package relies heavily on dietary fortification and micronutrient supplementation as well as 'improved nutrition for pregnant women' and pro-breastfeeding policies and campaigns.

It is unfortunate that the WHO Secretariat thinks that this publication is a contribution to the successful implementation of the Comprehensive Implementation Plan.

Monitor and evaluate

EB146/24 reports on a number of initiatives directed to improving the adequacy of nutrition monitoring globally.

Progress in global nutrition monitoring is appreciated but care is needed to ensure that program implementation is not compromised by the increasing expenditure on monitoring and evaluation.

Marketing of breastmilk substitute

The extent and depth of Code implementation is disappointing. Despite the legislation on the marketing of breast milk substitutes in 136 countries globally, full adherence has been lacking. It is unacceptable that about 38% of national pediatric associations source funding from manufacturers of breast milk substitutes.

The implementation of the NETCode Kit in monitoring adherence to the Code at national levels is commendable but at this stage only being used by a small number of countries.

The digital marketing strategies adopted by the industries needs to be considered in the revision of the Code to address the strategies adopted by the industries. Tight compliance monitoring systems are needed at country levels to ensure the adherence to recommended sugar and salt standards in the production of baby foods.

Support for breastfeeding is a continuing concern. Too many countries are lacking commitment to providing supportive space for mothers of young infants in order to support breastfeeding. Only 11% of countries offer paid maternity leave as recommended by ILO, 14% of countries have majority of deliveries in baby friendly facilities and only 18% of countries have legal measure for the full implementation of the Code.

Draft decision

The proposed draft decision would serve to streamline reporting to the governing bodies on a range of nutrition-related issues.

19. Accelerating efforts on food safety

In focus

This item [was added](#) to the provisional agenda as a consequence of a proposal from the US, EU, Japan, Canada, Australia, Mexico, Ethiopia, and Member States of the Africa Group.

[EB146/25](#) brings together a number of different streams of policy regarding food safety:

- issues highlighted through the First International Food Safety Conference and the International Forum on Food Safety and Trade (both held in early 2019), including harmonisation of food standards, adapting to new technologies, and food standards capacity-building for developing countries; see [WHO's index page](#) to both conferences;
- demands from within the Codex Alimentarius Commission for WHO to increase the funding of food science and guidance, including a proposal that such funding come from assessed contributions rather than depending on tied voluntary contributions; see [CX/CAC 19/42/14](#) and [CX/CAC 19/42/14 Add.1](#);
- evidence regarding the disease burden associated with foodborne illness, the emergence of new challenges in this field including technological developments and global warming, and the lack of attention to this issue by WHO's governing bodies since 2010 ([WHA63.3](#))

The Board is invited to note the report in [EB146/25](#) and to provide guidance on the Organization's response to foodborne diseases.

Background

[Tracker links](#) to previous governing body discussions about food.

[WHO \(2002\) Global strategy for food safety](#).

Criticism of WHO's funding of food science analysis from the Codex Alimentarius (see [CX/CAC 19/42/14](#) and [CX/CAC 19/42/14 Add.1](#)).

[WHO's index page](#) to the Addis Ababa Food Safety Conference and Geneva Food Safety and Trade Conference; both conferences supported by US, EU, Norway, Germany, Netherlands and Canada.

Neither food security nor food sovereignty were considered in either of the two 2019 conferences. It appears that the civil society networks engaging with the UN [Committee on Food Security](#) were not included in the conferences, despite the implications for food security.

PHM Comment

This item has far-reaching implications and MSs are urged to examine these implications closely.

The disease burden of food borne disease is significant and increased attention to food safety is needed. Global warming adds uncertainty and new threats which need to be managed. Strengthened regulation, regulatory capacity-building, harmonisation of food standards, and new technologies can play important roles in the control of food borne disease. However, other public health goods, such as nutrition, food sovereignty, and equity, must not be compromised in the name of food safety.

WHO's total budget is woefully inadequate and the shortfalls in WHO's food science capacity are a reflection of this. The lack of resources limit WHO's ability to contribute to updating food standards and to country and regional capacity building. More generally WHO has failed to pull its weight in the Codex and has too often allowed marketing objectives to drive food standards, rather than human health.

PHM urges MSs to lift the freeze on ACs and donors to untie their VCs so that WHO can participate more effectively in Codex decision making and give proper priority to health.

New technologies, including digital technologies and genomics, have significant potential to improve surveillance and outbreak investigation. However, they also have the potential to impact food systems in various different ways and their implications need to be carefully explored.

There are benefits to be gained from the harmonisation of food standards, including economies of scale and trade facilitation. However, such harmonisation needs to be negotiated at a regional level between countries at comparable levels of development. Top down harmonisation where L&MICs are persuaded to adopt stringent HIC standards carries significant risks.

There is a real possibility that, for some countries, upwards harmonisation of food standards, associated with more effective national policing, could impact negatively on nutrition and food security, and on small farmers' and small retailers' livelihoods (and rural development more generally). Large transnational corporations, active in global supply chains, will find it easier to conform to upwardly harmonised food standards than small scale peasant farmers and small market retailers. Under WTO rules harmonised Codex standards can be used to prevent L&MICs from restricting the importation and marketing of ultra-processed foods, and thus exacerbate the double burden of malnutrition. While food safety is important and trade facilitation can be beneficial, these should not come at the cost of community nutrition and food sovereignty.

The digitisation of monitoring systems and genome sequencing in outbreak investigation have the potential to promote food safety. However, they also have the potential to impact food systems in negative ways and their implications need to be carefully explored.

The adoption of new food safety technologies is being driven by HICs (host to transnational food corporations). While supporters of these technologies speak of reducing the burden of disease and reducing ecological damage, these claims necessitate scrutiny. L&MIC's should question who owns and benefits from these technologies, and whether the benefits from these technologies serve the communities using them or the companies who own them.

PHM urges MS to apply a level of scepticism to this project and ensure that the opportunities and risks presented by new technologies, harmonisation of food standards and regulatory frameworks are fully analysed. An appropriate balance must be struck to ensure that food security and food sovereignty are not compromised in the name of food safety.

PHM urges the EB to suspend consideration of this item pending a revised version of EB146/25 in which the implications of climate change, top down harmonisation and new technologies in relation to food systems, food security and food sovereignty are fully worked through.

20. Data and Innovation: Global Strategy on Digital Health

In focus

In response to the requests in resolution [WHA71.7](#) (2018), [EB146/26](#) summarises the [draft global strategy on digital health](#) including the purpose, vision, framework for action, and implementation, with strategic objectives. It also includes an action plan, which includes monitoring and evaluation. The Board is invited to consider a draft decision on the draft global strategy on digital health.

This item appears as a consequence of [WHA71.7](#) adopted in May 2018 which includes recommendations to MSs and requests of the DG, including that he report to WHA73 in May 2020.

Note the decision of the [Officers of the Board](#) to merge and integrate into this item the items proposed by the Government of India on Status of the global digital health strategy 2020–2024 and Discussion on the potential of a hosted partnership on digital health in accordance with the World Health Assembly resolution on partnerships (resolution [WHA63.10](#) (2010)).

The details of the Indian proposal are not available.

Background

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

See April 2019 announcement of WHO's first [Guideline](#) on digital health interventions. See [WHO Launches Digital Health Action Plan To Guide Expert Group's Work](#), Grace Ren, Health Policy Watch, 25 Oct 2019

See summary of [regional committee discussions](#) of the global strategy on digital health.

PHM Comment

Framework

As used in the draft strategy digital health is taken to mean “the field of knowledge and practice associated with the development and use of digital technologies to improve health” ([Draft global strategy](#), para 13)

The draft strategy identifies four guiding principles and four strategic objectives and proposes a range of policy options and actions under each of the strategic objectives:

- Promote global collaboration and advance the transfer of knowledge on digital health
- Advance the implementation of national digital health strategies
- Strengthen governance for digital health at global and national levels

- Advocate for people-centred health systems that are enabled by digital health

The eight applications prioritised for [evidence review for the Guideline](#) provides an indication of the scope of applications of digital technologies which are encompassed by the term ‘digital health’:

- birth notification,
- death notification
- stock notification and commodity management
- client-to-provider telemedicine
- provider-to-provider telemedicine
- targeted client communication (spread across five population groups),
- health worker decision support,
- tracking of patients’/clients’ health status and services,
- provision of educational and training content to health workers.

However, the scope of the draft strategy is wider than these well established applications and elsewhere in the strategy there are references to other uses of digital technologies for health such as the Internet of Things, machine learning, artificial intelligence, advance computing, big data analytics, blockchain and robotics.

The draft strategy includes in the annex a table identifying proposed actions for member states, for the Secretariat, and for ‘partners’ in relation to each of the four strategic objectives.

A non-strategic strategy

The draft strategy is largely *non-strategic* insofar as the ‘strategic objectives’ are not based on any clear analysis of the critical levers which could shape the development of the field. (The logic behind Fig 1 is not clearly evident; it is certainly not a standard program logic model.)

The identification of strategic objectives needs to be based on a clear analysis of trends, opportunities and risks, and the dynamics and drivers of development. The analysis of trends, opportunities and risks points to the ways in which the field should be reshaped. The analysis of the dynamics and drivers of development points to how the development of the field might be best steered towards those directions. The strategic objectives are then selected and moulded so as to most effectively impact on the dynamics and drivers to most effectively shape the development of the field.

In large degree this is a strategy to develop more strategies.

Key strategic issues are dispersed throughout the draft. For example, the term ‘interoperability’ appears in eight separate places in the objectives/actions table; the term ‘capacity-building’ appears in five different places in the table. The same issues are mentioned under various headings but without actually going into any depth about what is actually needed and how it will be achieved.

Objective 3, regarding governance, is conceived mainly as capacity building. The actual actions directed to governance range from international regulation, to the development of standards, to evaluation of particular applications, to the production of technical documents.

There are very real issues facing the digital health field which could be usefully considered in terms of:

1. Applications of specific digital technologies to health care and public health;
2. Nurturing the digital health ecosystem; and
3. Developing ICT infrastructure to support digital health.

Capacity building and governance are cross-cutting fields which apply to all three of the above.

There are significant challenges in relation to **specific applications of digital technologies** to health care and public health. These include:

- Promoting applications which have been evaluated and need to more widely implemented;
- Identifying, nurturing and steering innovative ideas which are not yet fully developed or properly evaluated;
- Exploring possible digital solutions for existing public health and health care challenges.

The challenges associated with **infostructure** involve nurturing the digital health ecosystem. This will include building communities of interest and collaboration around particular applications and particular types of applications (including data capture, repositories, registries and directories, big data, artificial intelligence). These communities of interest will contribute to the mapping and evaluating the field and identifying the need for (and developing) guidelines, standards and regulations around terminologies; data interchange and access standards; consent and access control; privacy, security and safety, etc.

Monitoring and steering the ICT infrastructure supporting digital health includes:

- Monitoring the adequacy of ICT infrastructure and advocating as necessary for changes in configuration, procurement and management of equipment and facilities, electronic comms infrastructure, processing and storage
- Ensuring adequate professional and technical support;
- Developing as necessary standards, methods, guidelines, and frameworks.

These challenges are all somewhat different; a strategic approach to their development will require a clear view of trends, opportunities and risks, and the dynamics and drivers of development. Such a view is not clearly articulated in EB146/26.

Capacity building and governance are cross-cutting fields which apply across all three sub-fields. **Capacity-building** will involve training and research, centres of excellence and technology transfer.

Governance includes the *governance of digital health* (planning, monitoring, evaluation; standards development and implementation; regulations and guidelines) and the *governance of the place of digital health* within the wider purposes of health care and public health (including

priorities for health sector investment and evaluating digital health applications in relation to wider health outcome objectives). This distinction is particularly important but is not recognised in the draft strategy before the Board.

Process of development

It appears that this draft strategy was largely produced in-house by Secretariat staff in consultation with MSs and regional committees (although it is not clear that the [advice of the regional committees](#) was fully integrated).

It appears that [WHO's eHealth collaborating centres](#) were not consulted, nor were other experts beyond WHO (such as those associated with ISO).

It seems likely that the draft strategy was finalised or close to finalised *before* the new [Digital Health Technical Advisory Group](#) was appointed. The inaugural meeting of the DH TAG was on the 24-25 October 2019 and EB146/26 was published 23 December.

In the present period, with virtually all of WHO's programme work being funded by donors, it is necessary to ask who paid for this strategy to be developed? Did it include the Bill and Melinda Gates Foundation and if so, given the links between that foundation and Microsoft, why is this not disclosed?

The significance of the several references to health data monetisation is perplexing. There may be contradictions between the emphasis on open source standards and the encouragement of data monetisation.

The meaning of, "Exploring the potential of global solutions and shared services should be considered as part of the national health strategy of Member States" is not clear.

The glass is half full

The tone of the draft strategy is very positive regarding the potential benefits of applying digital technologies to health care and public health.

Undoubtedly there are many applications which are already adding value and others that will emerge in due course.

However, actions like, "Support digital transformation being prioritised at national, regional and global levels" suggest enthusiasm untampered by a critical gaze.

Among the biggest risks are wasted money from misdirected ventures and roadblocks to future development arising from inappropriate decisions now. The authors of the strategy are clearly aware of such risks but there does not appear to have been any in depth analysis of the dynamics and drivers of such misdirections (including for example the marketing practices of private sector vendors or the challenges of gaining vendor compliance with standard information models).

Another risk arises from the implementation of sophisticated applications which are dependent on high quality information inputs at source. However, if the data being captured at source is inaccurate or poorly specified the products of the applications may be less useful or even dangerous. Rubbish in rubbish out.

The significance of reduced staffing levels, as a consequence of digital health implementation, is not considered in the draft strategy. This may have implications for the quality of care or program implementation. They also have implications for unemployment.

Technology transfer

The draft makes all of the right noises in terms of promoting digital health capacity in those countries which are at a relatively early stage or which have implemented in only a few areas. The draft relies heavily on 'collaboration', 'technical guidelines', 'technical assistance' and 'capacity-building' as the appropriate strategic actions.

However, it is not clear if the drafters of this strategy have fully explored the experience of technology transfer in other fields and fully appreciated the various barriers, including commercial secrecy and intellectual property protection, to technology transfer.

Secretariat capacity

The draft strategy is somewhat opaque regarding who will provide the technical support at country level. While globally oriented guidelines will be useful, it may be that in many cases direct person to person assistance, addressing unique challenges at the local level, may be more useful. However, it is not clear that the strategy foreshadows the capacity building for WHO regional and country offices that would be needed to ensure those offices are able to provide practical tailored advice regarding local issues.

PHM urges the Board to refer this draft to the new [Digital Health Technical Advisory Group](#) for a thorough revision before forwarding it to the Assembly.

21.2 Financing and implementation of the Programme budget 2018-2019 and outlook on financing of the Programme budget 2020-2021

In focus

In [EB146/30](#) the DG reports on the financing and implementation of the Programme budget 2018–2019 and the outlook for the financing of the Programme budget 2020–2021. The Board is invited to note the report.

Background

See WHO's [Programme Budget Portal for PB18-19](#). Note the:

- lack of support through core voluntary contributions
- underfunding of NCDs, HEP and Humanitarian response plans and other appeals.

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

See [Tracker links](#) to previous discussion of PB20-21.

Note the link between this item (regarding the outlook for PB20-21) and [Item 17.1](#) (regarding a funds mobilisation strategy for PB20-21).

PHM Comment

Funding uncertainty and allocation rigidity impacts on operational efficiency.

Base programmes expenditure as % of budget consistently low at 75% of approved budget (as of 30 Sept 2019). Flexible donor funds (CVCs) of \$147m corresponds to 5% of total financing of base programs (and only 15% of total donor contributions).

Donors exercise disproportionate power over WHO expenditure as a consequence of the ACs freeze and insistence on tied donor funding.

Financing of base programmes by category (including projections) as % of approved budget (as of 30 Sept 2019) varies wildly depending on popularity with donors. Communicable disease which is 86% donor-specified funded expected to be 123% financed. Compare NCDs which is only 55% donor-specified funded (and a much smaller absolute budget allocation) expected to be only 89% financed.

Lift the freeze on ACs; untie voluntary contributions, now!

22.1 WHO Reform

In focus

Involvement of NSAs in GB meetings

As agreed by the Executive Board at its 145th session, the Secretariat organized a web consultation with non-State actors to seek their views on their involvement in WHO governance in order to elaborate proposals for the governing bodies on that involvement. The report ([EB146/33](#)) describes the outcome of the consultation and outlines options for involving non-State actors in WHO governance, including restricting their current involvement. The Board is invited to note the report and to decide if and when the proposed new approach should be tested and evaluated before permanent changes are considered.

Governance (agenda control)

Further to the Board's request in decision EB144(3) (2019), the Director-General offers (in [EB146/32](#)) several recommendations drawn up after an informal consultation with Member States on governance reform in September 2019, aimed at reducing the number of items on governing body agendas, and consolidating and managing reporting requirements on similar subjects. The report also describes an approach to regional inputs into global strategies and action plans. The report includes a draft decision for the Board's consideration.

Written statements by MSs

In line with the Board's request at its 145th session, the Director-General provides (in [EB146/31](#)) revised draft guidelines for Member States to post written statements for governing body sessions on the WHO website. The Board is invited to consider the revised draft guidelines and also, subject to any further guidance it may wish to provide, to consider a draft decision regarding their application on a trial basis.

Background

Various aspects of WHO Reform have been under GB consideration for a long time. See [Tracker links](#) to previous governing body discussions.

NSA involvement in GB meetings

This item appears as a consequence of [EB144\(3\)](#) (from Jan 2019) which committed to changes in the Rules of Procedure for the Health Assembly broadly directed to agenda control and time management and requested a report on progress to EB146.

Under [Item 7.3 at EB144](#) the Board (informed in part by [EB144/34](#)) reviewed WHO's engagement with non-state actors and in [EB144\(3\)](#) decided to continue the discussion of WHO's engagement with non-state actors at EB145.

Accordingly, under [Item 6.1 at EB145](#) the Board considered this matter further, informed by [EB145/4](#). Following discussion (see [M1](#) and [M2](#)) it was agreed to undertake a web consultation with NSAs and bring a revised version of EB145/4 to EB146.

See report of [Web consultation with non-State actors on their participation in WHO governance](#) (also referred to in [EB146/33](#)).

See also the independent evaluation of FENSA implementation commissioned through the Evaluation Office and reported in [EB146/38 Add.2](#) (and in full [here](#)). The evaluation team reports that the Organisation does not have a formal appreciation of the benefits of NSA engagement; rather its concerns are weighted to risk control.

Governance (agenda control)

See also [note of meeting](#) of the DG with Officers of the Board on Oct 5-6 2019 which includes further discussion of the challenges of agenda control and corresponding proposals.

PHM Comment

NSA involvement in GB meetings

The People's Health Movement (PHM) considers the World Health Organisation (WHO) as the premier forum for global health governance and we have engaged actively with WHO since our formation in 2000, including through active participation to WHO's governing body meetings. We believe that civil society experiences and inputs represent a valuable input to WHO's work: they illustrate the diversity of the health landscape and are, more often than not, the sole channel through which a grassroots perspective on health-related issues reaches WHO's governing bodies.

Several of the proposals in [EB146/33](#) would have the effect of restricting and homogenising civil society input into the governing bodies.

We recognise the agenda pressure facing the governing bodies arising in part from the growing number of non-governmental organizations (NGOs) seeking to contribute to GB deliberations. We also recognize that the current system, under which NSAs' statements are delivered after the discussions among country representatives are closed, is of dubious efficacy.

The proposal for constituency-based consensus statements (para 19 of document EB146/33) would bunch organisations into a small number of constituencies which would have to find the lowest common denominator as part of achieving consensus. As a consequence, the specificity of positions and suggestions would be lost, making them less relevant for the forum they are addressing. Organisations that have a similar positions are already in a position to deliver joint statements and often do.

The views and positions of organizations that represent grassroots movements, advocating around Health for All, differ significantly from special purpose NGOs and professional organisations. The breadth of views available to delegates will be cramped and the voice of

grass roots organisations will be muffled if they have to be incorporated into grouped consensus statements.

Similarly, the proposal for a low cap on the number of statements per organisation would discriminate sharply against organisations such as MMI/PHM who take a broad view of global health policy and generally submit statements on relatively wide range of items.

The proposed cap on the number of participants per delegation (paras 20 and 21 of document EB146/33) seems quite arbitrary and again discriminates against 'federated' organisations such as MMI which includes a range of different affiliated organisations (including PHM) in its delegation.

Clearly the imposition of these caps will not improve the quality of civil society participation. It is not clear either how the proposed numbers have been estimated.

The Secretariat paper is extremely narrow in its purpose: how to restrict civil society contributions to GB debate and what do CSOs want in their engagement with WHO. In this context we note the report of the recent evaluation of the implementation of the FENSA ([EB146/38 Add.2](#)) which found that the Secretariat does not have an engagement strategy and in essence doesn't know or care about how its work could benefit from stronger civil society engagement.

Meanwhile because of WHO's parlous financial situation the philanthropies are increasingly dictating the Organisation's program and private sector entities are increasingly being incorporated into 'multi-stakeholder partnerships' and other 'public private partnerships'.

WHO mechanisms regulating cooperation with the private sector, FENSA included, have not offered an adequate response to questions of conflict of interest and related issues. Exactly because of this, we are discouraged to see that the WHO's suggestions allow even more intense participation of the private sector in WHO's governing bodies.

We urge the Secretariat to propose a way forward that is oriented towards nurturing the richness of content provided by organizations representative of grassroots movements, and is more critical towards the role of private interests that are finding their way to WHO discussions and operations.

Instead of offering solutions that would effectively limit the contributions of civil society, we urge the Secretariat to undertake a comprehensive review (including detailed case studies) of its approach to civil society engagement including the potential benefits of nurturing rather than restricting such engagements.

Governance (agenda control)

The report and proposed decision make sense.

Written statements

The provision for MS written statements and the proposed guidelines make sense.

22.2 Engagement with non-State actors

In focus

In [EB146/34](#) the DG provides the report for 2019 on the implementation of the Framework of Engagement with Non-State Actors (FENSA) in accordance with resolution [WHA69.10](#) (2016) and subparagraph 68(a) of the [Framework of Engagement with Non-State Actors](#). The Board is invited to note the report.

The report notes that the following efforts have been made to improve and promote FENSA compliance:

- ongoing efforts are being made to ensure familiarity with FENSA. This includes training of WHO staff in all regions and publication of the FENSA handbook for NSAs in the six official WHO languages.
- The WHO register of NSAs has been enhanced and updated with new information.
- The WHO Secretariat is in discussions with various NSAs about how WHO can leverage their technical knowledge in support of its normative and standard-setting function, especially in areas where WHO doesn't currently have "evidence based and quality-appraised guidance" (par.7).

See also (for consideration under Item 23.1): [EB146/38 Add.2 - Evaluation of implementation of FENSA](#) which provides a less-than-flattering evaluation of implementation of FENSA (it does not set out to evaluate the framework itself). This evaluation was commissioned in July 2019, and is the first ever evaluation of FENSA submitted to the EB. Some of the challenges with implementation the report identifies include:

- During implementation, greater focus has been placed on FENSA's risk-aversion and management goals than its engagement-enhancing goals. The report notes that this emphasis "might be leading to missed opportunities for positive engagement" with NSAs (par.23).
- Limited progress on ensuring the full functionality of the register of NSAs, which is aimed at improving transparency around NSAs in official relations with WHO.
- The absence of a comprehensive, actionable strategy and associated implementation plan to achieve the overall aims of the FENSA at all three levels of WHO and inadequate resources for implementing FENSA, which has contributed to inconsistent implementation of FENSA.
- An over-emphasis on reporting on FENSA outputs and activities, but no substantial monitoring of the effects of FENSA implementation.

The Board will have (in [EB146/3](#)) the advice of the PBAC on the Secretariat report and the independent evaluation.

In [EB146/35](#) the Secretariat reports on applications by NSAs for admittance into official relations and reviews collaboration with one third of the non-State actors in official relations in order to decide whether to maintain their official relations. The Board will have the advice of the PBAC (in [EB146/3](#)) on these applications and evaluations. The Board is invited to note the report

([EB146/35](#)) and to consider a draft decision (at para 21 of EB146/35). Significantly, the Bill and Melinda Gates Foundation (BMGF) is among the 66 NSAs undergoing a triennial review of their collaboration with WHO. PHM has previously criticised the disproportionate influence of the BMGF in shaping the WHO health agenda through the scale of its tied contributions.

Background

See previous annual reports on FENSA implementation: 2018 ([EB144/36](#)), 2017 ([EB142/29](#)), 2016 ([EB140/42](#)).

See [Tracker links](#) to previous discussions of non-state actors (NSAs) and the FENSA.

Regarding the financial contribution of NSAs to WHO's work, and voluntary contributions more generally, see:

- [A71/INF./5 - Voluntary contributions by fund and by contributor, 2018](#)
- [EB146/30](#) - Financing and implementation of the Programme budget 2018–2019
- [WHO PB Portal](#) for more comprehensive financial data and infographics.

See also [How McKinsey infiltrated the world of global public health: The Gates Foundation brought billions of dollars to the sector — and a business-friendly ethos consultants could exploit](#). By Julia Belluz and Marine Buissonniere on Vox.com, Dec 13, 2019, 9:10am EST

PHM Comment

FENSA blindspot: oversight over philanthropies, tied contributions from multilateral and bilateral donors, and MS promoting corporate interests

While WHO applies due diligence to NGOs and professional associations, WHO's operational programs are held hostage to the conditionality of the contributions of philanthropies, multilateral and bilateral donors (almost all of which are tightly ear-marked) and interventions of member states on behalf of transnational supply companies (especially pharma); promote policies which are directed at shoring up corporate profit rather than addressing public health needs.

Donors that make large contributions, e.g. philanthropic organisations like the Bill and Melinda Gates Foundation – have a disproportionate influence in shaping the WHO agenda and there is little transparency regarding the terms under which donors participate in WHO's financing dialogues and its newly established [Partner's Forum](#), or regarding the relationship between these fundraising processes and the agenda-setting process within WHO.

These issues of donor influence in shaping the global health governance agenda go beyond narrow issues of conflict of interest (COI). FENSA has historically focused on identifying and managing risks of COI. These have been conceptualised as the risks of quid pro quo relationships emerging between for-profit businesses and WHO officials or departments. COI thus focuses on the potential for organisations and/or individuals to extract financial benefits by exerting undue influence on WHO officials.

In some ways the issue of donor influence over the WHO agenda is much more foundational. Donors don't necessarily derive direct financial benefits from engagements in WHO processes. However, their financial contributions create opportunities for them to exercise significant political power over decision-making within WHO – perhaps to a greater extent than smaller MS or civil society organisations that represent the interests of grassroots communities but do not have the financial weight to secure a seat at the table where funding and policy decisions are being taken. Through the mechanism of tied contributions, in particular, donors have the opportunity to influence what health issues WHO will address and what modes of intervention they will prioritise (e.g. interventions led by the private sector vs. the public-sector, or an emphasis on curative interventions vs. also focusing on the social determinants of health).

[EB146/29](#) discusses the Programme Budget for 2020-2021 and the WHO Resource Mobilisation Strategy. In par.7 the DG argues for consolidating its relationships with the small base of existing donors which are responsible for contributing more than 50% of voluntary contributions to its budget, but also flags the necessity of diversifying the range of organisations making voluntary contributions. This suggests that, in the absence of significant increases in the level of assessed contributions, WHO will continue to depend on donors to finance its operations and be held hostage to their preferences.

Community engagement

Does WHO have a strategic approach to the benefits of community engagement including through organisations in official relations? The report on FENSA implementation clearly indicates that WHO could do more in terms of nurturing positive engagements with NSAs and community engagement more generally. To curb the risks associated with donor dependence and agenda capture, WHO must also ensure that it institutionalises opportunities for routine and meaningful engagement with representatives of grassroots communities, in keeping with the Alma Ata Declaration's recognition that "the people have the right and duty to participate individually and collectively in the planning and implementation of their health care".

23.1 Evaluation: update and proposed workplan for 2020-2021

In focus

The Evaluation Office's report ([EB146/38](#)) describes progress in implementing the evaluation workplan for the biennium 2018–2019 and sets out the proposed evaluation workplan for the biennium 2020–2021. The latter incorporates both the corporate and decentralized evaluations planned and developed through consultation at senior management level across the Organization and discussed with the Independent Expert Oversight Advisory Committee. The Board will be invited to note the report and approve the proposed workplan.

The Board will also be invited to note a report ([EB146/38 Add.1](#)) on a review of 40 years of primary health care implementation at country level produced in response to a request by the Board at its 142nd session.

The Evaluation Office will further submit a report ([EB146/38 Add.2](#)) on the initial evaluation of the implementation of the Framework of Engagement with Non-State Actors for the Board's consideration.

Background

This is a regular item on EB agendas ([Tracker links here](#)).

PHM Comment

Report and workplan (EB146/38)

The Office has accumulated a number of useful evaluations ([here](#)). The workplan foreshadows further useful evaluations.

The Office continues to use large consultancy firms for many of its evaluations. PHM is of the view that greater use of Secretariat staff (not from the program being evaluated) and use of individual resource people with links to WHO could produce evaluation reports of comparable quality with the additional benefit of building up the evaluation expertise and culture of organisational learning in the Secretariat.

The Office's interpretation of 'organisational learning' remains quite mechanical, largely restricted to reporting on the implementation or otherwise of evaluation recommendations. In many usages the concept of organisational learning is much richer than this.

Primary health care evaluation (EB146/38 Add.1)

See [Tracker links](#) to previous discussions of PHC in global governing bodies.

The Executive Summary is quite general; so general as to verge on the banal. The report ([here](#) in full) decontextualises country experience by conducting its inquiry through generic questions on specific issues. The form that PHC may take is highly contingent; on history, economic capacity, workforce, and other factors. Fragmenting country experience into answers to specific questions abstracts that experience from its context.

PHM appreciates that the Evaluation builds on the Vision Statement prepared for Astana which describes PHC as having three inter-related and synergistic components:

1. Meeting people's health needs through comprehensive promotive, protective, preventive, curative, rehabilitative, and palliative care throughout the life course, strategically prioritizing key health care services aimed at individuals and families through primary care and the population through public health functions as the central elements of integrated health services;
2. Systematically addressing the broader determinants of health (including social, economic and environmental factors, as well as individual characteristics and behaviour) through evidence-informed policies and actions across all sectors; and
3. Empowering individuals, families, and communities to optimize their health, as advocates for policies that promote and protect health and well-being, as codevelopers of health and social services, and as self-carers and caregivers.

However, there is a range of issues which has been ignored, as a consequence of the survey methodology, including: the scaling up challenge (from autonomous centres of excellence to system-wide implementation), questions about public versus mixed service delivery, relationships with community, and ensuring political space for policy contestation regarding multisectoral action for health.

PHM urges the EB to ask the Evaluation Office to undertake a follow up evaluation using a case study methodology rather than the decontextualising survey methodology used here.

See also [PHM comment from EB144](#).

FENSA implementation evaluation (EB146/38 Add.2)

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

[EB146/38 Add.2](#) summarises a plain-speaking evaluation of FENSA implementation.

Significant weaknesses in implementation are noted. The implementation plan was of limited usefulness; implementation has been undertaken in an ad hoc, fragmented and unsystematic manner; some activities and deliverables have been neglected; the time frame for implementation was overly optimistic. The cost of implementation has not been monitored but further resources are needed to fully implement FENSA.

Risk management (risk aversion) appears to have been given greater weighting compared with promoting and enhancing engagement, preventing otherwise positive engagements from occurring. WHO does not have an over-arching engagement strategy which limits what can be said in communications about FENSA

The evaluation team offers some useful recommendations. They highlight the challenge of enacting change within WHO's decentralized structure and offer some suggestions to better address this.

It appears that FENSA was forced on senior management who have still not articulated a clear case regarding the potential benefits of engagement and the conditions for realising those benefits.

PHM urges the Evaluation Office to commission a further case evaluation based on case studies through which both the possible risks and potential benefits of engagement can be illustrated and from which guidelines to manage the risks and cultivate the benefits can be articulated.

25.5 Human resources: update

In focus

[EB146/48](#) summarizes the trends in the workforce (drawing on the [Workforce data report](#)).

It summarises the 'new operating model': better aligning the three levels around programmes, emergencies, business operations, and external relations and governance.

It describes progress with respect to recruitment and selection, the global internship programme, performance management, staff learning and development, career pathways, mobility, and an enabling working environment.

The Board is invited to note the report.

Background

[Tracker links](#) to previous discussions of (WHO's) Human Resources.

PHM Comment

The data show a significant increase in use of consultants (particularly when expressed as FTEs) and agreements for performance of work and individuals hired on special service agreements. While increasing use of 'other contractual arrangements' provides staffing flexibility in the face of financial uncertainty (due to donor unpredictability) there are costs including dissipation of corporate memory and failure to build technical expertise.

Progress is being made in increasing the number of women in professional and higher categories and the number of developing country nationals in director positions

The data provided regarding under- and over-representation of particular countries and regions in the staff of the Secretariat are very misleading. The formula for determining that a country has the 'right number' of professional staff (Resolution [WHA56.35](#)) gives undue weight to the financial contribution of the country. This is inappropriate. The bias should be towards countries with needs for human resource development and high public health needs. The idea that the USA is under-represented with 188 nationals in the Secretariat (not including PAHO) is absurd.

The report describes the 'new operating model' for WHO that aligns the three levels of the Organization around four common pillars: programmes, emergencies, business operations, and external relations and governance. This model is said to clarify roles across the three levels and to place emphasis on strengthening country-level capacity.

PHM appreciates the expansion of opportunities for young people from developing countries to participate in WHO's Global internship program. From Jan 2020 stipends will be payable (see para 13) thanks to a grant from the Wellcome Trust.