People's Health Movement
Background and Commentary on Items coming before WHA72, May 2019

Introduction

As part of its contribution to WHO Watch, the People's Health Movement prepares a commentary on the meetings of WHO's global governing bodies.

PHM's WHO Tracker provides links to the Secretariat reports for all of the items on the WHA71 agenda plus a search capacity to assist in reviewing previous discussions and resolutions.

GHWatch/WHA72 provides links to PHM item commentaries and policy briefs and to WHO Watch statements to the Assembly during the debate.

This document provides a compendium of PHM item commentaries. This version of this document is published 17 May 2019 at which time several Secretariat papers are yet to be published and accordingly the commentaries on those items are not included here. Several other papers were published very late and PHM commentaries on those items are still under development.

Feedback welcome: edit[at]phmovement.org.

Contents

11.1 Proposed program budget 2020-21

In focus

Following review and discussion by the regional committees and the EB, the proposed programme budget 2020–2021 is presented for consideration by the Assembly in A72/4.

A72/5 presents the *Impact Framework* for the Thirteenth General Programme of Work including: an overarching measure of healthy life expectancy; indices for each of the triple billion targets; and a set of programmatic targets.

A72/INF./2 responds to a number of questions arising from the discussion of the PB20-21 in EB144 in January 2019.

A72/INF./3 responds to questions raised in January 2019 by the Executive Board and the PBAC about the new five-year strategy and budget of the Global Polio Eradication Initiative covering the period 2019–2023, their place in the WHO Programme budget 2020–2021 and in the investment case for the Thirteenth General Programme of Work, 2019–2023 (GPW 13) and their relation to WHO's Strategic Action Plan on Polio Transition 2018–2023. (See extended discussion of polio financing in PHM comment on Item 11.3 on this agenda, here.) That commissioned from the Polish

Background

The investment case

- Main page of the Investment Case
- The full investment case
- Background technical paper

See also, for comparison:

- GPW12
- PB18-19

PHM Comment

Totally inadequate

The proposed PB envisages a marginal (8%) increase in total expenditure, in part through including provision for emergency response / operations and appeals (previously treated on an ad hoc basis, see para 27 of A72/4) and in part through a provision for inflation.

The base component of the budget is projected to increase by 13%, in part through including a portion of the polio budget in the base component reflecting the progressive mainstreaming of functions previously supported under the polio eradication campaign (see A72/INF./3).

The proposed budget also includes provision for increased funding for country offices and increased funding for 'data and innovation' (largely funded through 'efficiency savings' in Geneva). Finally there is provision to pay the UN levy to support the strengthening of the resident coordinator system and a contribution to the UN Sustainable Development Group.

The total budget is totally inadequate. PHM calls for a reworking of the WHO investment case for 2019-2023 (and the technical paper) to estimate the health gain which could be achieved if the WHO budget was doubled or tripled.

Following changing priorities

It is hard to get a clear sense of changing priorities from this budget, notwithstanding the useful crosswalk in Table 1 of A72/INF./2, partly because of the inclusion and distribution of polio into the base.

However HIV and hepatitis, tuberculosis and neglected tropical diseases appear to have been significantly reduced. It is not clear whether the savings so achieved have gone into strengthening country offices or strengthening normative (science) work at headquarters.

There are significant increases in vaccine-preventable diseases and national health policies and integrated people centred health services. Presumably the polio transitions fund has contributed to these increases.

The donor chokehold remains in place

Para 100: "The assessed contributions will remain at the same level as in 2018–2019 and, as a result, the entire increase for the base segment of the Proposed programme budget 2020–2021 will be financed from voluntary contributions specified, core voluntary contributions and a new classification of funding – thematic and strategic engagement funds as noted in paragraph 29 above, which are currently classified as voluntary contributions – core".

Tight earmarking of the bulk of voluntary contributions is expected to continue (see Fig 6) which in effect means that the donors will continue to shape WHO's priorities.

Reduced financial transparency

There appears to have been a dramatic loss of detail/transparency in this new budget structure. The number of line items has been reduced 32 'programs' in PB18-19 to 12 'outcome' items in the proposed

PB20-21. These will be much less useful in terms of knowing where the money is going. Presumably the donors will demand a full programmatic budget so they can choose what they will agree to fund.

A72/4 explains that "driving impact is the primary focus of WHO is accountability" which presumably is why expenditure budgeting has been focused on outcomes rather than organisational units. A72/4 explains (para 48) the shift to outcome line items in terms of a recognition that outcomes are produced by the combined efforts of multiple programs, country health systems and multisectoral action.

These should not be exclusive alternatives. Budgeting against outcomes is useful but it is also necessary to see how resources are distributed between organisational units (other than regional and country offices and headquarters).

The focus on outcomes as a way of promoting collaboration across the organisation sits beside the increasing pressure on organisational units to be involved in fundraising. Competitive fundraising has been a serious fragmenting factor within the Secretariat for several decades.

Outputs

The reduced number of budgetary line items is complemented by the definition of 42 identified outputs and a measurement system which, focuses on six dimensions in the measurement of these outputs: leadership, normative work, technical support at the country level, results which lead to impacts, value for money, and integration of gender, equity and human rights. The measurement of each of these six 'dimensions' will be based on four or five 'attributes', each of which may involve between three and five 'elements'.

A72/4 promises (para 68) that measures of the 42 outputs (involving a total of up to 6000 'elements') will be updated on the WHO Programme Budget Portal every quarter and results will be posted annually.This would increased to over 1 million 'elements' if all 42 outputs were to be measured for 194 countries.

The methodology proposed for the measurement of outputs is innovative but untested. It is certainly the case that many of the output indicators adopted in previous program budgets were meaningless. However, the transaction costs of this new system may exceed its usefulness.

Impact framework

The proposed impact framework has three levels:

1. Programmatic indicators and associated milestone values (for 2023);
2. The triple billion targets, corresponding to the headline goals in GPW13; and
3. Healthy Life Expectancy (HALE) as the top level single integrative measure.

At this health assembly member states are being asked simply to endorse the programmatic indicators. The proposed programmatic milestone values (for 2023) and the triple billion targets and the measurement of healthy life expectancy are subject to continuing methodological work and consultation.

The proposed milestone values are often quite arbitrary. Some milestones not yet defined. It is a work in progress.

Some of the programmatic indicators are optional, to be prioritized by countries, and others are global. However, in many cases achievement of the global indicators depend on their being achieved nationally. Need to identify core and optional indicators at country level.

It is not clear how or if the measurement framework will address the results chain (theory of change) principle. Thus in relation to service coverage there is a precondition indicator, namely an increase in public health expenditure. However there are indicators for stroke and BP but the salt reduction indicator (present in the October 2018 version of the impact framework) has been removed from Annex 4 of A72/5.

Public relations spin

WHO's budget documents are always slanted towards shaping perceptions but this draft PB20-21 may be more so than most.

The September 'Investment case' is directed to showing that donating to WHO is an investment in health (and economic) outcomes rather than simply an expenditure: "30 M lives saved; 100 M healthy years of live gained; 2-4%of economic growth in low and middle income countries". If only it were so easy!

The 'triple billion' slogan is quite good as marketing slogans go and the Investment Case is a slick product. However, the implicit assumption behind this kind of PR approach is that the obstacles to adequate funding of WHO are perceptions that WHO is not results-oriented, and not as country focused as it should be. ("This may have been true under Dr Chan but will not be so under Dr Tedros" - so the PR message is framed.)

The DG's 'value for money' strategy (EB144/6) is part of the PR offensive. The message is that while his predecessor might have neglected efficiency but Dr Tedros will give it close attention. Donors can be assured that they will get the biggest bang for their buck under the new administration.

This PR approach may well underestimate the sophistication and cynicism of the donor strategists. They know that the continued donor chokehold over the Organization is necessary to prevent the Secretariat from acting on resolutions which threaten the interests of the high income countries and their corporations. The criticisms of the Secretariat for not being results-focused or sufficiently country focused are largely a smokescreen to justify the continuing chokehold. If some sections of the Secretariat are more focused on process than outcomes it is in large part because of the distortions created by the competition for donor funding.

11.2 Public health emergency preparedness and response

In focus

Three papers are circulated for this agenda item:

- A72/6 - Sixth report of the Independent Oversight and Advisory Committee for the WHO Health Emergencies Programme (IOAC-WHE)
- A72/7 - WHO's work in health emergencies
- A72/8 - International Health Regulations (2005)

There have been no draft resolutions or decisions published regarding this item to this point. The Assembly in just invited to note A72/7 and A72/8.

It seems likely that the discussion will focus on the deteriorating Ebola situation in DRC, including the death of Dr Mouzoko on 19 April 2019 in Butembo. It is also likely that delegates will comment on the underfunding of the WHE Program, including the Ebola response.

The success of ring vaccination with an investigational vaccine is also likely to attract comment.

Background

For a summary of the prehistory of the Health Emergencies Programme see PHM Background Note for Item 12.1 at WHA70.

See WHE Program webpage and the Q&A page regarding the program.

WHO's Emergency Response Framework (2017) provides more useful detail.

See also the R&D blueprint (A70/10 and A71/6).

Brief history of the IHRs in A69/21

Saga of core capacities in Appendix 2 to the draft Five Year Global Strategic Plan.

Note the summary of country capacity in WHO's Global Health Observatory and the IHR Monitoring Framework.

Note the role of the Strategic Partnership for IHRs and Health Security in funding core capacity strengthening and its JEE Dashboard.

See also the Five Year Global Strategic Plan for IHR capacity building (A71/8) and endorsed in WHA71(15).

See Tracker links to previous discussions of WHO's Health Emergencies Program including PHM comments.

PHM Comment

Global situation

The Ebola crisis in DRC (North Kivu and Ituri) continued to deteriorate. The WHO/DRC response has been complicated by violence and displacements.

Cyclone Idai has wreaked devastation in Mozambique.

If Cyclone Fani in the Bay of Bengal had hit the Rohinga refugees in Cox's Bazaar the loss of life would have been horrendous.

The Saudi bombardment in Yemen continues unchecked, supported by the US and other 'like-minded' countries.

The common factors include a low level of economic development, weak health systems, inadequate housing and WASH infrastructure, and vulnerable nutrition.

Meanwhile unchecked global warming is delivering extreme weather events with increased frequency and of greater intensity (Cyclone Idai in Mozambique; Cyclone Fani in Bay of Bengal). It is also delivering crop failures and the movement of vectors and pathogens.

WHO's work in emergencies

In this context WHO's Health Emergencies Program is to be commended and appreciated. It is extraordinary that leading Western countries prevented WHO from establishing this program for so long.

However the WHE Program is clearly facing a serious funding crisis. In the short to medium term there is no alternative except for continued and repeated appeals to donors although they seem to be suffering from increasing 'fatigue'.

In the longer term the freeze on ACs must be lifted.

IHRs

There has been an increasing uptake of JEEs but slow progress on National Action Plans for Health Security. There has been some improvement in IHR core capacities although many countries are lagging, particularly in managing points of entry.

There is a significant overlap between building IHR core capacities and the broader challenge of health system strengthening (effective case management, immunisation, prompt alert and notification, laboratory network). Developing country officials have expressed concern 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.

Delays in event notification remain a problem as does poor compliance with the regulations regarding additional measures.

Economic development and fiscal capacity remain critical.

11.3 Polio

In focus

Eradication

Document A72/9 provides a status update on polio eradication, summarizing programmatic, epidemiological and financial challenges to securing a lasting polio-free world. The report includes:

- an update on the GPEI Polio endgame strategy 2019-2023;
- an overview of the current prevalence of wild type (Nigeria, Afghanistan, Pakistan) and vaccine-derived poliovirus (DRC(type 2), Kenya(2), Somalia(2&3), Niger(2), Nigeria(2), Mozambique (2), Syria and Papua New Guinea(1)) ;
- an overview of progress in the phased removal of oral polio vaccines;
- a report on progress regarding containment facilities and containment certification which had been a focus of discussion at WHA71 (Item 12.9).

Transition

Document A72/10 provides a status update on the implementation of the strategic action plan on Polio Transition (here), which was noted (A71/9) by the Seventy-first World Health Assembly in May 2018. The report:

- summarises the strategic action plan and the tasks of transition;
- describes Secretariat activities directed to developing national transition plans;
- refers to the transition of polio assets into other programmes;
- describes the outcomes of the high level meeting called in late 2018 to discuss implementation of the transition plan and the governance of the Polio Post-certification Strategy; which highlighted the need to
    - design transition planning on a country by country basis;
    - sort out the confusion arising from the inclusion of transition functions in WHO's base budget (with fund-raising implications) and the extension of the GPEI for a further five years;
- reports on country visits and their outcomes
- describes on-going tasks including
    - further country visits and work on national transition plans;
    - a further high level stakeholders meeting to consider programmatic, funding and governance implications of transition
    - sorting out the 'future governance of polio transition' (and after the GPEI);
    - sorting out the financial and human resource implications;
    - the development of communications and advocacy materials;
    - the development of monitoring arrangements regarding polio transition.

Background

The GPEI

The GPEI is a multiagency organisation. It has five main partners: WHO and UNICEF are the main implementation partners; the Gates Foundation and Rotary International are the leading funding partners; CDC provides technical resources and facilitates US funding. As part of the transition strategy GAVI will join the polio oversight board.

The management and advisory structure which has pointed been put in place to govern the GPEI is complex (here). The polio oversight board (POB) is the supreme governing body supported by the Finance and accountability committee (FAC) and the strategy committee and informed by the polio partners group (PPG). In addition there are a series of management groups with responsibilities linked to the objectives of the Polio eradication and endgame strategic plan 2013-2018 (and now the polio endgame strategy 2019-2023). The management groups are accountable to the POB through the Strategy Committee.

The strategic plan 2013-2018 was supposed to take us to the completion of the eradication stage but it didn't and so the new endgame strategy 2019-2023 was developed (finalised early in 2019) which is based on finally interrupting wild polio virus transmission in 2020.

See also the strategic action plan on polio transition (2018-2023) which was noted by WHA 71.

The Independent Monitoring Board (IMB) assesses progress and provides independent guidance on Objective 1 of the GPEI Strategic Plan – the detection and interruption of poliovirus. The Polio transition independent monitoring board (TIMB) provides advice regarding the process of transition.

WHO's strategic advisory group of experts on immunisation (SAGE) also provides advice, as does the Emergency Committee established to advise under Polio under the International Health Regulations. The global commission for the certification of the eradication of poliomyelitis is tasked with certifying eradication (see Polio post certification strategy).

The finance and accountability committee has principal oversight of the financial needs funding sources resource allocations and expenditures. This includes "advising donors on financial needs" and "driving cross agency alignment on financial needs and resource requirements".

The history of the GPEI since 1984 is reflected in the escalating expenditure and the changing involvement of donors (here). In 1988, when an estimated 350 000 cases of poliomyelitis occurred in 125 countries, the World Health Assembly resolved to eradicate polio globally.

WHO and UNICEF are the main implementation agents and manage and account for separate budgets (but see integrated report on expenditures for 2017 here). UNICEF's main role is vaccine procurement and supply and advocacy and communication. WHO takes the lead in technical planning and monitoring and evaluation; in outbreak management, delivery of immunisation, containment planning and transition planning.

WHO's work in polio is described on its Polio topic page and in the PB 18-19 mid-term report on the polio category.

See Tracker links to previous discussions of Polio in the EB and WHA and various documents, resolutions and decisions.

Eradication, transition, containment

Eradication is about interrupting the transmission of wild poliovirus and controlling the risks of vaccine derived paralytic polio (through rapid detection and limitation of infections and withdrawal of live vaccine).

Transition is about: maintaining the broader public health functions presently supported by the GPEI; maintaining and redeploying the polio workforce; maintaining and redirecting the funding flows (see paras 17-18 in A72/10); and restructuring the governance arrangements created under the GPEI.

Containment is about ensuring that laboratory stored virus is securely contained.

PHM Comment

Eradication of wild type polio and control of vaccine derived disease face continuing barriers associated with conflict, war, displacement, weak health systems, fragile states, etc.

The continued financing of eradication activities is a major challenge. Transition planning raises complex and difficult issues regarding operations, human resources, and funding flows.

It appears that there are still some shortfalls in the development of national transition plans and fund-raising for such plans where domestic funding is not available remains uncertain.

Options for the future governance of polio transition are a key issue for discussion.

Facility related containment remains problematic (see discussion of containment under item 12.9 at WHA71).

See PHM comment at WHA71 regarding the longer range issues regarding global health governance and global health policy making arising from the 1988 commitment to polio eradication.

11.4 Implementation of the 2030 Agenda for Sustainable Development

In focus

This report (A72/11 and A72/11 Rev.1) on the attainment of the health-related Sustainable Development Goals has been prepared in line with resolution WHA69.11 (2016) . Part I of the report summarizes global and regional progress made by Member States towards achieving Goal 3 (Ensure healthy lives and promote well-being for all at all ages), as well as other health-related goals and targets. Part II describes progress made in implementing resolution WHA69.11.

A previous report arising from WHA69.11 was considered by WHA70 (in A70/35) in response to which the Assembly adopted decision WHA70(22) which requested that future reports include responses to WHA68.15 on the strengthening of emergency and essential surgical care and anaesthesia. The Secretariat appears to have overlooked this request in the preparation of A72/11 released on April 1 but this was rectified with the release of A72/11 Rev.1 on 16 May.

Background

See the 2030 Agenda for Sustainable Development as adopted by the UNGA.

See Goal 3 Targets on UN SDG site

See World Health Statistics 2018: Monitoring health for the SDGs.

See also the SDG Index and Dashboard.

Tracker links to previous discussions of the 2030 Agenda for Sustainable Development

PHM Comment

SDG shortfalls point to core contradiction

Part I of A72/11 is a burning indictment of the health consequences of the prevailing global governance regime. Likewise the more detailed figures provided in WHS18 and the actual 2030 targets here.

Part I of A72/11 needs to be read far more widely than just within WHO. Health science students and practitioners should read this and ask why. Journalists should read and ask why. Parliamentarians should read and ask why.

Unfortunately A72/11 does not seek to explain the looming shortfalls in the SDG targets.

Various reports including the SDG Index and Dashboard report show that no country is on track to achieve the SDGs by 2030. In fact the number of people living in poverty in Africa is increasing; likewise the number of children who are stunted. Global maternal mortality (now 216 per 100,000 live births) is unlikely to reach the target of 70 by 2030 if the rate in Africa remains high (currently 542).

Part II lists a range of WHO programs, projects and engagements and seeks to demonstrate how, through these activities, WHO is contributing to the achievement of the SDGs. Many of these are admirable initiatives and WHO staff are to be congratulated for their commitment and achievement.

Unfortunately, despite these valiant efforts, in many areas the shortfalls with respect to achieving the health related targets are growing. A72/11 does not seek to explain these widening shortfalls. Simply listing all of the activities which WHO is contributing to is not enough.

In passing we note the heavy burden of preventable illness and disability associated with shortfalls in surgical, obstetric and anaesthetic capacity. In essence as the document makes clear these are part and parcel of weak health systems generally.

The report comments that many countries face a seriously inadequate health workforce, including surgery obstetrics and anaesthesiology, but does not refer to the continued net migration of medical practitioners and specialists from the global South to the North and the need for financial compensation for this human resources theft.

The key to understanding the widening shortfalls in achievement is the contradiction between the humanistic aspirations of the SDGs and the dynamics of liberalised transnational capitalism.

> Simply measuring poverty distracts attention from the distribution of global wealth and global income and the dynamics which maintain extreme inequalities of wealth and income;
>
> Simply measuring stunting distracts attention from the world food system including protection and price supports in the rich world; the capture of arable land, water, and energy to over-feed the rich; the global structures which drive small farmers off their land.
>
> Simply measuring health care impoverishment distracts attention from the global forces, political and economic, which extract the wealth of resource rich countries leaving governments without the fiscal capacity to underwrite health care costs; which enforce high prices of medicines in order to maintain pharma profits and export earnings.
>
> Simply noting the impact of global warming on food production and environmental disaster distracts attention from the corporate and political forces seeking to prevent and defer action on greenhouse gas emissions.

The SDGs provide an inspiring vision of ‘the world we want’. However, they also serve to distract attention from the economic and political forces which are preventing the realisation of this vision. In effect they are helping to maintain an appearance of good faith and commitment on the part of those who are in effect working to prevent the achievement of the goals. This is the legitimation function of the SDGs.

PHM urges member state delegates to speak truth to power at the Health Assembly.

PHM urges health activists around the world to raise public awareness and lobby their governments around the disaster that is looming behind the language of ‘sustainable development’. Key talking points in such advocacy include:

- insist on naming liberalised transnational capitalism as a failed economic system (driving widening inequality, deepening the imbalances between productive capacity and consumption, increasing financial fragility and deepening our peonage to the banks through increasing debt);
- insist on naming neoliberalism as a policy package (austerity, small government, privatisation, tax competition and corporate privilege) being implemented in order to protect the transnational corporations and preserve the privileges of the transnational capitalist elite;
- recognise the contradictions between the neoliberal program on the one hand and the goals of reducing poverty, promoting Health for All, and mitigating climate change on the other;
- reject the bizarre assumption that the SDGs can be paid for through increased economic growth (as measured by GDP) without attention to the harms or benefits of the market transactions so measured;
- insist on the need for a New International Economic Order as called for in the 1978 Alma-Ata Declaration (and completely ignored in the October 2018 Astana Declaration);
- insist on naming the xenophobic backlash, and the populist demagoguery which is stoking it, as barriers to effective action on the SDGs; and
- continue to denounce the restrictions imposed on WHO’s capacity and its voice by the donor chokehold and the ACs freeze.

These issues are all strikingly absent from A72/11.

Internal contradictions

In previous commentaries we have focused on the contradictions within and across the SDGs themselves. These remain important.

See PHM comment on Item 31.2 at WHA69 which highlighted:

- Goal 12 which promises sustainable consumption and production but lacks any drivers to achieve this;
- Goal 8 which promises high rates of economic growth but ignores the contradictions between economic growth and ecological sustainability; and
- the contradictions between the SDGs and the real effects of 'free trade';

See also PHM comment on Item 16.1 at WHA70 which highlighted:

- the need for a real world 'theory of change' regarding how the SDGs could be achieved;
- the dangers of the drive towards 'multi-stakeholder partnerships', as in SDG17.16 and 17.17, which projects universal beneficence and completely ignores the Trojan horse functions of many such 'partnerships';
- the importance of following the health implications of all of the SDGs.

Two of the chapters in the current Global Health Watch1 also carry powerful criticisms of the SDGs:

- A1: Sustainable Development Goals in the age of Neoliberalism
- A2: 'Leave No One Behind' — are SDGs the way forward?

SDG8 proposes that the cost of meeting the rest of the goals will be met through 'sustained per capita economic growth'. GHW comments that the assumed metric, GDP, is a measure of market transactions regardless of their contribution to ecological sustainability or human development (or health). Manufacturing and deploying weapons of mass destruction makes a powerful contribution to GDP.

SDG8 calls for full employment (Target 8.5) and for 'higher levels of economic productivity' ('increase in real GDP per employed person'). This combination of targets ignores the role of productivity increases (as measured) in creating unemployment! Conventional economic theory assumes that the labour displaced by increased productivity will simply be re-employed in new forms of better-paying work. What such theory disregards is the massive displacement of agricultural labour from 'increased productivity' in agriculture and the huge mobilisation of Third World workers (displaced from agriculture) in global manufacturing: "too many workers competing for too few jobs to produce too many goods or services for too few consumers with too little income to afford them without increasing their already high levels of personal debt".

GHW5 also comments on the continuing call for increased 'development assistance' as a key pathway to funding the SDGs. This strategy has failed to impact on sustainable development over several decades even while fragmenting health systems and placing huge administrative burdens of governments. Meanwhile no action is proposed on tax evasion through transfer pricing and tax havens nor on the pressures of tax competition and corporate tax extortion which have held back tax revenues and public spending.

GHW5 also comments on principle of reciprocity (non-discrimination) in the current regime of trade agreements; a principle which treats poor countries the same as rich countries despite massive differences in economic and political power. The New International Economic Order, which features in the Alma-Ata Declaration (and is notably missing from the 2018 Astana Declaration), envisaged discrimination in favour of developing countries to be structured into a rules based trading regime. Not only are modern trade agreements non-discriminatory (in the sense of including few or no provisions for 'special and differential treatment') but they discriminate blatantly in favour of the rich countries through extreme IP provisions, regulatory harmonisation and investor protection.

[1] GHW5 was the last in the series to be edited by the late Dr Amit Sengupta who was an outstanding researcher/ commentator/ activist on the political economy of health globally, including the significance of the SDGs in relation to the neoliberal project.

GHW5 also addresses the difficult topic of population control. It is established that family sizes fall with economic development and the provision of social protection. However as population levels level or fall in the rich countries the call is increasingly heard for encouragement for population growth through fertility and (selective) immigration. GHW5 labels this as a Ponzi population policy:

> *Its argument is that, with population aging, immigration and/or incentives for larger families should be encouraged to re-swell a comparatively shrinking working age cohort (those between 15 and 64 years).The economic rationale is that the taxes collected from the productivity of the working age population is needed to pay for the services and pensions of a proportionately greater and increasing number of elderly. That makes sense, perhaps, for the short-term. But fast forward 40 or 50 years, and the re-swelled working age cohort has itself become elderly (and far more numerous), requiring an ever larger expansion in the base of the working age population. And so on, and on, and on.*

11.5 Universal health coverage

In focus

There are three sub-items included under this item:

- Primary health care towards universal health coverage (A72/12 and resolution EB144.R9)
- Community health workers delivering primary health care: opportunities and challenges (A72/13 and resolution EB144.R4)
- Preparation for the high-level meeting of the General Assembly on universal health coverage (A72/14 and resolution EB144.R10)

Primary health care towards universal health coverage (A72/12)

Forty years after the Declaration of Alma-Ata in 1978 the Global Conference on Primary Health Care convened in Astana, Kazakhstan in October 2018 and produced the Astana Declaration.

A72/12, prepared by the DG for this sub-item (with additional parts added after EB144):

- notes the agreements and commitments enshrined in the Astana Declaration;
- briefly reviews contemporary health and health system challenges;
- sets forth a 'vision' for primary health care including the case for PHC;
- sets forth briefly the proposed operational framework for advancing PHC as a fundamental structural model for health system development;
- foreshadows further work to clarify what the Secretariat will do to support member states' implementation of PHC.

A72/12 also refers to the Global Action Plan for healthy lives and well-being for all (a joint initiative of 11 global health organisations and structured around achieving the SDGs and especially the Health goals); see in particular the mapping document and the accelerator documents; and highlights the significance of PHC as an 'accelerator' for the achievement of the Global Action Plan.

The Health Assembly is invited to adopt the draft resolution recommended by the Executive Board in resolution EB144.R9. The draft resolution is mainly couched in general terms but there are three specific commitments for the Secretariat:

- to develop an operational framework for primary health care;
- to strengthen the capacity of the Secretariat, including at regional and country levels, to support member states in strengthening primary health care; and
- to report regularly to the Assembly on progress.

A72/12 refers to the Astana Declaration and to several key documents prepared by WHO & UNICEF as inputs to the Astana Conference:

- A Vision for primary health care in the 21st century;
- Primary health care: transforming vision into action: Operational Framework;
- Background documents: an index page linking to
    - the Vision and the Operational Framework,
    - a three promised documents on Making the Case for PHC:
        - the Economic case,
        - the Health outcomes case (still not posted), and
        - the Responsiveness case (still not posted).
    - a series of excellent technical papers on the 'operational levers' included in the Operational Framework:
        - Health in All Policies / Multisectoral Action
        - Empowering individuals, families & communities (still not posted)
        - PHC Health workforce
        - Strategic purchasing (still not posted)
        - The private sector
        - Quality in PHC
        - Digital technologies
        - Integrating public health & primary care
        - Integrating health services
        - The role of hospitals in PHC
        - Antimicrobial resistance
        - PHC and health emergencies
        - Rural primary care (still not posted)
    - a series of technical papers on 'meeting health needs through PHC':
        - Sexual, reproductive, maternal, newborn, child & adolescent Health
        - Older people
        - Rehabilitative care
        - Palliative care
        - Noncommunicable diseases (still not posted)
        - Mental health
        - Communicable diseases
        - HIV/AIDS
        - Traditional and complementary medicine (still not posted);
    - and a series of regional reports on PHC.

EB144.R9 would commit WHO to developing an operational framework for PHC development which presumably will be based on the framework developed by the Secretariat in the lead up to Astana (although this framework is not mentioned). It is intriguing that several of the technical papers, envisaged as part of the framework and promised in the lead up to Astana, have still not been posted (see above).

Community health workers delivering primary health care: opportunities and challenges (A72/13)

In the Declaration of Astana (Kazakhstan, October 2018) Heads of State and Government committed themselves to investing in the primary health care workforce in order to accelerate progress towards universal health coverage.

Previous commitments to health workforce development include:

- the WHO Global Strategy on Human Resources for Health: Workforce 2030 (resolution WHA69.19 (2016)),
- the 2016 UN GA resolution on Global health and foreign policy: health employment and economic growth (A/RES/71/159),
- the WHO investment case 2019–2023, and
- WHO's GPW13 (2019-23),

A72/13 focuses on the education and deployment of community health workers within the primary health care team. The report is based on a new WHO guideline, launched at the Astana Conference, on opportunities and challenges for the successful education, remuneration, deployment and supervision of community health workers (see also an abridged version of the guideline in Lancet Global Health).

Document A72/13:

- starts with generalities about workforce development and the status of CHWs in the wider workforce context;
- comments on the problems of evidence and lists some common shortcomings in CHW programs;
- refers to the new WHO guideline; and
- elaborates:
    - lists 6 key principles which should be realised in CHW programs;
    - lists 7 policy recommendations (selection, certification, supervision, compensation, entitlements, career development, service delivery models);
    - lists key actions for the design and implementation of CHW program:
        - at the national level, and
        - for international organisations (donors and IGOs).

EB144 recommends that the Assembly adopt the resolution contained in EB144.R4 which would:

- take note of the new WHO Guideline;
- urges member states to:
    - implement the Guideline;
    - implement the Code on Recruitment of Health Personnel (WHA68.11);
    - invest in community health worker programs;
- invites diverse 'partners' including global health initiatives and other donors to implement the Guideline;
- requests the DG to:
    - collect information;
    - monitor implementation of the Guideline;
    - support implementation;
    - strengthen the Organization's capacity;
    - report every three years.

Preparation for the high-level meeting of the United Nations General Assembly on universal health coverage (A72/14)

In 2017, the United Nations General Assembly decided in Resolution 72/139 to hold a high-level meeting on universal health coverage in 2019 and requested WHO to collaborate closely with the President of the General Assembly, in consultation with Member States, to ensure the most effective and efficient outcomes.

Document A72/14 reports on the Secretariat's preparations to date and:

- notes recent statistics regarding financial barriers to health care and notes the limitations of disease oriented programs;
- notes the inclusion of UHC in the SDGs;
- reviews indicative data regarding service coverage;
- overviews recent data on catastrophic health expenditure and health care impoverishment;
- reviews the scope, modalities, format and organisation of the proposed HLM; and
- reflects on the possible themes of the Political Declaration and on the process through which it will be developed.

The Assembly is invited to adopt the draft resolution (contained in EB144.R10) which:

- reviews a range of previous commitments regarding UHC and PHC;
- regrets the stagnation of progress towards UHC;

- urges member states to progress UHC and PHC through a range of pathways including financing, planning, workforce development, access to medicines and various clinical technologies, research and development, health literacy, intersectoral action for health, monitoring and evaluation;
- calls upon 'development cooperation partners' to support progress on SDG3 including support for the Global Action Plan;
- requests the DG to:
    - support member states in working towards UHC and health systems strengthening;
    - raise awareness among parliamentarians;
    - facilitate learning and capacity building;
    - prepare a report on UHC for the UNGA HLM;
    - submit biennial reports on implementing this resolution and WHA69.11.

Universal Health in the 21st Century: 40 Years of Alma-Ata". Report of the High-Level PAHO Commission

Not listed for discussion but certain to be referred to in debate is the recently published PAHO report on Universal Health in the 21st Century, available here.

This excellent report breaks with the standard WHO / World Bank line in several key aspects.

Background

The Declaration of Astana comprises a general vision statement; an affirmation of rights and needs; a commitment to making bold choices and building sustainable primary health care; and a recognition of key drivers for successful implementation of PHC.

The Civil Society Astana Statement on Primary Health Care provides a useful alternative perspective on PHC.

The Vision document, produced by WHO and UNICEF (but not explicitly endorsed by the Astana Conference):

- provides three reasons why a focus on PHC is critical at this time (adapting to complexity, effective and efficient, a prerequisite for UHC and the health SDGs);
- presents PHC in terms of three basic components (primary care and public health, intersectoral action, and empowering individuals, families and communities);
- summarises a series of three 'governance, policy and finance' levers and 10 'operational' levers which are presented in more detail in the Operational framework and Background documents (see listed and linked above).

Note the intention of the Evaluation Office of WHO to undertake a review of 40 years of primary health care implementation at the country level in 2019. See EB144/51, paras 15-20 (and PHM comment on the proposed evaluation).

See Tracker links to previous discussions of PHC and UHC.

See Tracker links to previous discussions of HRH, including CHWs.

The Global Action Plan for healthy lives and well-being for all (SDGs) was endorsed by 11 'global health organisations'. It maps the responsibilities and commitments of all 11 organisations in relation to the goals and targets of the 2030 Agenda for Sustainable Development and posits a number of 'accelerators' for driving the implementation of the Plan; these accelerators are explored in more detail in the draft accelerator frames.

See Tracker links to previous Assembly discussions of the health-related SDGs.

PHM Comment

Primary health care

PHM believes that the package as a whole represents a major step forward for WHO.

The construction of PHC is good. The three reasons make sense and the three components encapsulate in large degree the vision of Alma-Ata for a 21st Century context (see Vision, p 14).

One of the three components, is described in summary as “primary care and public health functions”. However, in several of the Operational Levers there is much more about primary care than about public health functions. MS are urged to mention this weakness.

The discussion of PHC in the PAHO Commission report provides a more comprehensive and deeper account.

PHM has two major criticisms of the new model of PHC articulated in the official documents.

A new international economic order

An element of the Alma-Ata Declaration which has been completely expunged in the Astana Declaration and the new documents produced for Astana is the call for a new international economic order (NIEO, A/RES/S-6/3201, 1974).

Equitable economic and social development will require rejection of the currently dominant neoliberal paradigm and establishment of a sustainable and equitable economic order globally and nationally.

Globalised capitalism confronts an ever-looming crisis of over-production and over-accumulation. The ‘crisis of overproduction’ refers to the overhang of productive capacity over demand, particularly as high wage employment shrinks, replaced by precarious, casual, low wage service employment and the transfer of manufacturing to ever-lower wage platforms. As the excess productive capacity becomes increasingly evident, capital shifts from investing in green-fields production facilities to speculating in shares, housing, currency and financial derivatives. With the increasing flow of capital to the banks (‘over-accumulation’), rather than real investment, the urgency for the banks of on-lending rises and is effected through a myriad of pathways: credit cards, mortgages, government bonds, corporate consolidation and lending for speculation. For a while debt-funded consumption supports demand until confidence lapses and the house of cards collapses. The arrest of production and the destruction of value clears the deck for the next cycle.

Neoliberalism is a policy package designed to manage the instabilities and crises of globalised capitalism in the interests of the transnational capitalist elite. This policy package impacts on population health and health policy in many ways:

- opening up health care to private investment through the privatisation of health services;
- the immiseration of populations through unemployment, under-employment and precarious low wage jobs;
- destruction of small farmers’ livelihoods and rural to urban migration;
- austerity and the dismantling of the welfare state;
- deregulation (eg environmental pollution, food production and retailing, building standards, gambling, gun control, private sector service delivery, international financial flows, tax evasion and avoidance, etc).

The economic crisis contributes to and is exacerbated by geopolitical turmoil: wars and violence (imperial and local), global warming (impacting on food, water, housing, cities, etc) and mass desperation and migration. The negative impacts on population health and on health care are profound and expose capitalism and the neoliberal policy regime to the risk of widespread and destabilising delegitimation.

Economic and political instabilities reflect and reproduce inequities associated with gender, caste, race, disability and sexual orientation, which are of basic importance to the fullest attainment of health for all and to the reduction of the gap in the health status within and between countries.

PHM calls on member states to remind the Secretariat of the history and significance of the call for a NIEO (A/RES/S-6/3201, 1974) and the continuing need for a contemporary version of this call.

The relationship between PHC and UHC

There is some confusion apparent in the documents regarding the relationship between PHC and UHC.

The International Advisory Group which was appointed to assist in the development of the strategy was entitled the International Advisory Group on Primary Health Care for Universal Health Coverage which suggests that UHC is somehow the ultimate goal and the PHC model is to be somehow harnessed towards that end.

Likewise it is unfortunate that this sub-item is labelled as 'Primary health care towards universal health coverage' which suggests that PHC is simply a means to an end, that end being UHC.

This perspective is evident also in the passage:

> *Put simply, now is a good time to both review and adapt the Alma-Ata Declaration and develop a new vision of primary health care (PHC) as a foundation of universal health coverage, for the SDG era and beyond. Vision page iv.*

However in the body of the Vision there are several passages which posit PHC as a prerequisite for the achievement of UHC:

> *UHC and the health-related SDGs can only be sustainably achieved with a stronger emphasis on PHC.*
>
> *A new approach to primary health care is central to achieving the SDGs and UHC.*

The construction of PHC as a precondition for achievement of both UHC and the SDGs brings these different frameworks together with greater coherence than has been evident previously. PHM commends the Secretariat for this formulation of PHC as a necessary prerequisite for the achievement of UHC. PHC is so much more than UHC.

Missing documents

There are several technical papers which were promised in the lead up to Astana but have still not been produced. These include:

- the 'health outcomes' and the 'responsiveness case' for primary health care;
- the 'operational levers papers' on 'empowering individuals, families & communities', 'strategic purchasing' and 'rural primary health care';
- and the technical papers on 'noncommunicable diseases' and 'traditional and complementary medicine'.

Member states may wish to ask the Secretariat why these papers have not been released.

The slogan 'UHC' obscures more than it conveys

In the context of prevailing global health policy discourse the celebration of 'UHC', understood as financial protection against high out-of-pocket health care charges, serves to obscure two critical policy debates.

In relation to health care financing the debate is between single payer versus health insurance markets. Single payer (public financing) provides for policy leverage over efficiency, equity, quality and safety. Health insurance markets entrench and promote inequity, system wide inefficiency and erect barriers to expenditure control and clinical governance.

In relation to health care delivery the debate is between integrated comprehensive public provision versus mixed/stratified service delivery. Integrated comprehensive public provision facilitates health care system development, equitable distribution of resources, the efficient use of resources and effective clinical governance. Mixed/stratified service delivery entrenches and promotes inequitable resource allocation, inefficient use of resources and erects barriers to clinical governance.

WHO's governing body resolutions and technical reports explicitly or implicitly support single payer health care financing and integrated comprehensive service delivery with a major if note dominant role for the public sector.

The neoliberal policy package (advanced through the development banks, the major bilateral donors and the corporate sector) requires competitive health insurance markets; the expansion of private sector service delivery (restricting the public sector to a safety net function); preferential development of high technology acute care (because it provides more profit opportunities than PHC); and profit-driven health system development.

WHO (like the rest of the UN system) is increasingly controlled by its donors, rather than its member states. This control is exercised through the capping of assessed contributions (supplemented by tightly tied voluntary contributions) and the progressive transfer of WHO functions to new vertical global health alliances ('multi-stakeholder partnerships'), accountable to donors rather than member state governing bodies.

However, WHO and its donors are co-dependent. While WHO depends on the donors for funding, the donors need WHO (albeit hobbled) to help to shore up the perceived legitimacy of economic globalisation and the neoliberal project.

The celebration of UHC, and the papering-over of the underlying policy debates, serves to shore up the perceived legitimacy of neoliberal globalised capitalism and to obscure its impacts on health and health care (widening inequities, barriers to access, catastrophic out of pocket health care expenditures, inefficiencies and variable quality).

The discussion of private sector engagement in the Operational Levers is problematic (vision here). While it mentions the risks associated with unregulated private sector delivery, the matrix of actions is dominated by private sector engagement rather than regulation and nothing about funding reform. By contrast the Technical Paper on the Private Sector recognises the reality that many countries have mixed health care delivery and highlights the regulatory and funding challenges facing policy makers seeking to harness the resources of the private sector.

The implementation of public interest policy is much more difficult in a marketised health system with private sector dominance with consequent shortfalls in quality, effectiveness and efficiency. Overservicing and clustering of providers in high income suburbs are common. Partnerships with the private sector generally lead to private extraction of profits at the expense of public health.

A high level of private sector involvement is inimical to PHC and the achievement of UHC in particular. UHC should be based on single payer financing and built mainly on a unified public funded system, with most service provision through public institutions.

The promised paper on "Strategic purchasing" or "Purchasing and payment systems" appears to have been not finalised. However, PHM appreciates:

At the community level, the delivery of predefined service packages focused on specific diseases has left large gaps in coverage, depriving the population of the significant benefits of comprehensive integrated community-informed and person-centred health services.

As health systems evolve, in line with each country's technical and financial resources, packages of services aimed at dealing with specific health problems are progressively replaced by fully integrated, comprehensive, people-centred primary care.

The PAHO Commission report departs from the standard WHO description of UHC which is agnostic with respect to financing mechanisms and institutional arrangements for health care delivery. In contrast the PAHO Commission report articulates clear principles regarding financing and institutional arrangements required for universal health.

Community health workers

PHM welcomes the focus on CHWs as part of the PHC team and supports in general terms the 6 key principles and 7 policy recommendations.

We look forward to a more extended discussion of the role that CHWs can play in addressing the social determinants of health, including through intersectoral liaison and through community mobilising. The function of CHWs can be much more than simply 'service providers'.

Political Declaration

PHM urges MSs to support the inclusion of PHC (as a pre-requisite for UHC and for the SDGs) and endorsement of the importance of CHWs (for PHC, UHC and the SDGs) in the Political Declaration.

PHM urges MSs to endorse the Vision and the Operating Framework documents and to request the DG to develop these ideas for the draft Political Declaration.

PHM urges the MSs to endorse the mapping and 'accelerator frames' developed for the Global Action Plan for healthy lives and well-being for all and request the Secretariat to incorporate the principles developed into the Political Declaration.

It is worth noting that while A72/14 comments (para 23) that, "The draft declaration may also include an accountability framework that holds all actors, in particular governments, accountable to universal health coverage commitments", there is nothing in EB144.R10 which would progress this possibility. PHM urges MS to add such a provision to EB144.R10.

PHM urges MSs to add to EB144.R10 the principles regarding PHC, health system financing and institutional arrangements for health care delivery articulated in the PAHO Commission Report.

11.6 Health, environment and climate change

In focus

In line with decision EB142(5) (2018) the Board has two reports for its consideration: A72/15 and A72/16.

Draft WHO global strategy on health, environment and climate change: the transformation needed to improve lives and well-being sustainably through healthy environments (A72/15)

A72/15 presents a draft global strategy on health, environment and climate change. The strategy presented in A72/15 is supported by a more detailed web annex. An earlier version of this draft strategy was considered and broadly by the EB in January and was subject to further consultation in March 2019. An earlier draft had been considered by regional committees (see paras 4-10 of EB144/3).

In para 46 the Assembly is invited to note A72/15 and to request a progress report to WHA74 in 2021.

The draft global strategy commences with a Scoping statement, a useful review of the Challenges and a Vision statement.

It then outlines six Strategic Objectives around which the global strategy is framed:

1. Primary prevention: to scale up action on health determinants for health protection and improvement in the 2030 Agenda for Sustainable Development
2. Cross-sectoral action: to act on determinants of health in all policies and in all sectors
3. Strengthened health sector: to strengthen health sector leadership, governance and coordination roles
4. Building support: to build mechanisms for governance, and political and social support
5. Enhanced evidence and communication: to generate the evidence base on risks and solutions, and to efficiently communicate that information to guide choices and investments
6. Monitoring: to guide actions by monitoring progress towards the Sustainable Development Goals

The draft strategy then lists a number of Implementation Platforms:

- An empowered health sector
- Stronger national and subnational platforms for cross-sectoral policy-making

- Key settings as sites for interventions (households, schools, workplaces, businesses*, health care facilities, cities, etc)
- Partnerships for a social movement for healthier environments
- Multilateral environmental, health and development agreements
- Platforms for the SDGs
- Evidence and monitoring

The draft strategy then focuses on WHO's Role and Leadership in Global Health. This is summarised in Figure 2 and elaborated in relation to the three Strategic Priorities adopted in GPW13 (promoting healthier populations, addressing environmental health emergencies, achieving UHC including environmental health services).

This section (on WHO's role) is supplemented by an extended web annex which:

- Lists a range of resolutions adopted by regional committees and the WHA which in aggregate provide the mandate for the draft global strategy;
- Lists the extant commitments arising from such resolutions in the areas of:
    - Water, sanitation, waste and hygiene,
    - Climate and ecosystem change,
    - Air pollution,
    - Chemical safety,
    - Occupational risks and working environment,
    - Radiation; and
- Lists the priority interventions in the key settings (in particular, cities and households);
- Lists initiatives targeted towards specific vulnerable groups, in particular, children.

The monitoring of progress in relation to the draft global strategy is based on targets and indicators already adopted under the SDGs.

Draft global plan of action on climate change and health in small island developing States (A72/16)

At the 23rd session of the Conference of the Parties to the UNFCCC in Bonn in October 2015 WHO launched a 'special initiative' on climate change and health in small island developing States (SIDS). This initiative was adopted into the GPW13 as one of five 'platforms' from which GPW13 is to be implemented, in particular the Healthier Populations strategic priority area.

In 2018, the Executive Board adopted decision EB142(5) on health, environment and climate change in which the Director-General was requested to develop "a draft action plan for the platform to address the health effects of climate change initially in small island developing States".

An earlier version of the draft global plan of action was considered at EB144 (M9). See Watchers' notes.

A72/16 provides an update on progress made on this draft action plan. In para 30 the Assembly is invited to note A72/16 and to request a progress report to WHA74 in 2021.

The draft global plan of action includes:

- Background, reviewing the key issues, summarising work in train and describing the process of developing this global plan;
- Vision, focusing explicitly on adaptation (but a stronger voice for SIDS in decision-making around mitigation is implied in the body of the plan);
- Scoping, identifying as within scope, WHO support to SIDS:
    - understanding and policies to address (adapt to) impacts of climate change on health;
    - health system strengthening in SIDS, including climate resilience, ecological sustainability, preventative orientation and closer integration across health programs;
    - to promote mitigation action within and beyond SIDS;
- Four 'strategic lines of action':
    1. Empowerment: Supporting health leadership in small island developing States to engage nationally and internationally

1.1. Establish at WHO a small island developing States hub or alternative coordination mechanism on small island developing States to provide support to climate change, environment and other priority health issues
1.2. Provide health sector inputs to the United Nations Framework Convention on Climate Change and stakeholders leading relevant national climate change processes (e.g. national adaptation plans, national communications, nationally determined contributions)

2. Evidence: Building the business case for investment
2.1. In collaboration with the United Nations Framework Convention on Climate Change, develop or update national climate and health country profiles for every small island developing State
2.2. Identify, support and build on existing centres of excellence for increasing capacity, conducting assessments, data analysis, research and implementation of actions, including with organizations and universities that have regional mandates

3. Implementation: Preparedness for climate risks, adaptation, and health-promoting mitigation policies
3.1. Support small island developing States through regional frameworks to build climate resilient health systems;
3.2. Develop and implement programmes to raise awareness and build capacity for adaptation and disease prevention both by people and by the health system [in SIDS];

4. Resources: Facilitating access to climate and health finance
4.1. Lead a process to identify new and innovative forms of funding and resource mobilization mechanisms
4.2. WHO will pursue the process to become an accredited agency for the Green Climate Fund and facilitate support to small island developing States

- Monitoring and reporting of progress

Background

Tracker links to previous discussions of environment and climate change

PHM EB144 comment and notes of debate

PHM Comment

Draft WHO global strategy on health, environment and climate change

This is an excellent draft global strategy. PHM urges member states to strongly support it. It is an excellent strategy but needs to be further strengthened before consideration at WHA72.

In relation to climate change the report needs to exhibit a greater degree of urgency, including reference to the findings of the IPCC special report on "Global Warming of 1.5 ºC" (not mentioned in A72/15).

Warming beyond 1.5C would be extremely dangerous for human health and we may exceed 1.5C in 12 or so years. The next decade will decide whether we stay below 1.5º, 2º or 3º C. The IPCC report should be a game-changer in the climate change debate. Whether it will be remains to be seen but WHO should be championing it vigorously with this in mind.

Insofar as there is a political analysis underlying this strategy it is structured around 'sectors'. The 'health sector' needs to engage with 'other sectors' to emphasise the risks to health arising from continued environmental pollution and global warming. This is a very limited frame of analysis.

Where is the analysis of climate denialism, including both its corporate sponsors and their political puppets? WHO has named and excluded the tobacco industry but makes only the most obscure references to the climate hoodlums who are seeking to defer action on global warming in order to maintain

the profits of fossil fuel and related industries. The indictment extends further to the financial corporations, executives and investors who seek to preserve their income streams from fossil fuel investments for as long as possible.

Where is the analysis of 21st Century transnational capitalism and its dependence on producing and consuming stuff; externalising costs to the environment (as in the two recent Brazil tailings dam disasters), and avoiding regulation?

The global strategy correctly identifies the need for 'partnerships for a social movement for healthier environments' and the need to mobilise public support "for more sustainable and health-promoting development choices". However WHO does not have a strong track record in terms of building real partnerships with social movements. This is a concrete challenge for the Secretariat at all levels.

The references in para 4 to "the part of the environment that can reasonably be modified" is not explained in either A72/15 or the web annex. There is no reference to the criteria for such a judgement nor are any examples offered. Short of sunspots, gamma ray bursts and volcanoes humanity must accept a far reaching stewardship for the wellbeing of our earthly home.

The section in the web annex on vulnerable groups is clearly incomplete as it only considers children. There are no references in the annex to gender or to indigenous populations.

The Global Strategy for Women's, Children's and Adolescents' Health, (2016–2030) highlights Water, sanitation and hygiene and Indoor air pollution as particular risks / exposures affecting women (page 21). Indoor air pollution was highlighted again in the Secretariat report (A68/16) on 20 years after the Beijing Declaration. WHA60.25 adopted the Strategy for integrating gender analysis and actions into the work of WHO (presented in A60/19 and reviewed under Item 21.3 F on this agenda).

WHO's mandate in relation to indigenous health appears to be thinner than with respect to women. A WHO fact sheet, published in 2007, mentions poor sanitation and access to potable water. It does not mention the environmental health consequences of displacement of indigenous peoples through colonisation and the encroachments of agriculture, mining and deforestation. See also the UN Declaration on the Rights of Indigenous Peoples.

Further consideration of indigenous peoples, in the development of the global strategy, would be of particular significance in view of the cultural challenges associated with "transforming our way of living, working, producing, consuming and governing" (from para 3 of the draft global strategy). Many indigenous peoples have traditional concepts of humans' relationship to our environment which emphasise custodianship, harmony and the rights of Mother Earth and all who depend on her. Such concepts should not be beyond the scope of WHO. Article 2(l) of WHO's Constitution establishes as one of WHO's functions "to foster the ability to live harmoniously in a changing total environment".

'Buen vivir' refers to a philosophy arising among the indigenous peoples of the Andes which has been seen by many as providing inspiration in relation to the transformations called for in the draft global strategy. See Calisto Friant and Langmore (2015). "The Buen Vivir: A Policy to Survive the Anthropocene?" Global Policy 6(1): 64-71.

The draft global strategy would be improved through a stronger consideration of the cultural challenges of 'surviving the anthropocene'. One of these challenges concerns security and solidarity. Many instances from around the world demonstrate that when people are insecure (in relation to food, money, violence, etc) they are generally less open to the massive changes in production and consumption that are necessary if humanity is to mitigate and adapt to climate change. Numerous instances also demonstrate the willingness of corporate executives and politicians to resist action on climate change because of risks to their power and wealth. These are in part issues of accountability (as implied in the draft global strategy) but they are also issues of culture and this needs to be acknowledged.

Another area which is not discussed in the draft global strategy is funding for action on environmental health and climate change in the context of obscene inequalities in wealth (individual, national) globally. Reference is made to SDG13, to 'Double the amount of climate finance for health protection in low- and middle-income countries' but justice calls for more than charity. The global economy has been and is being structured, deliberately, to extend the rights of transnational corporations and to preserve the privileges of the already wealthy. Para 29, which calls for a social movement to drive political will, hints at an awareness of the wider political economy of action on climate change and other environmental crises.

Many of these dynamics are implied but unstated in the draft global strategy. This is understandable in terms of the realpolitik of WHO's governing bodies but it does weaken the message.

Funding is the critical vulnerability of this draft global strategy. Under the donor chokehold (frozen ACs and tied VCs) the DG has little discretion in funding programs like this one unless donors can be found who are willing to fund it.

PHM urges MS to support the draft global strategy, including ensuring sufficient funding. The planet cannot wait. However, as the strategy points out, the outcome will depend on " mobilizing public support for more sustainable and health-promoting development choices".

Draft global plan of action on climate change and health in small island developing states

This draft global plan of action appears to project a range of practical measures to progress the 'special initiative' launched at the Bonn COP in October 2015.

While adaptation is a major policy challenge for SIDS, leaders of several SIDS have made a major contribution to mitigation through their international advocacy. This is recognised in the draft global plan including a commitment for WHO to support such engagement.

One element of adaptation of particular relevance for small island states is provision for orderly migration should it become necessary. While this is controversial the possibility of such a scenario needs to be recognised. It is not mentioned in the document.

The reference in para 11 to "transforming health services in small island developing States away from a model of curative services with escalating costs and towards a model based on disease prevention, climate resilience and sustainability" could be interpreted as a blanket critique of health systems in SIDS. It could perhaps be reworded.

PHM urges MS to support the draft global plan of action and to guarantee appropriate funding.

11.7 Access to medicines and vaccines

In focus

As requested by Member States during the Seventy-first World Health Assembly (Decision WHA71(8)), the Secretariat prepared a draft road map report outlining the programming of WHO's work on access to medicines, vaccines and health products (A72/17). Lack of access to safe, effective, quality and affordable medicines and vaccines continues to impede progress towards universal health coverage. The draft road map elaborates activities, actions and deliverables for the period 2019−2023 to address the challenges and suggests milestones for implementation.

The Executive Board considered the draft road map in January and the draft before the Assembly has been modified and added to following that discussion.

Discussion of the road map at WHA is likely to be dominated by the conflict over the Italian resolution, as modified, regarding price transparency. See below.

Background

This item emerged at WHA70 in May 2017. There had been an existing agenda item dealing with shortages of medicines (from EB138 in Jan 2016) which had been proceeding (see Tracker links to discussions of shortages).

Then in September 2016 the UN Secretary General's High Level Panel on Access to Medicines reported (announcement here). The report of the HLP provides a broad sweep of recommendations (see Executive Summary) relating to:

- TRIPS flexibilities and TRIPS-plus provisions;
- publicly funded research;

- new incentives for research;
- stronger accountability of governments;
- a stronger role for the UN SG and UNGA;
- greater disclosure and transparency by corporations;
- complete transparency regarding clinical trials;
- publicly accessible databases regarding patents and related data regarding medicines and vaccines.

The Officers of the Board chose not to include any reference to the HLP report in the agenda for EB140 but during consideration of the agenda (PSR1) it was agreed to discuss it under Item 8.5 ('Follow up of CEWG'). In this discussion (in the 11th meeting here) the USA (supported by Europe, Switzerland and Japan) was strongly opposed to any further consideration of the HLP report. Contrary views were presented by Colombia, India, Thailand, Algeria, Brazil, Iran and South Africa.

Including the HLP Report on the agenda for WHA70 (May 2017) was discussed in the 18th session of EB140 (PSR18) and it was agreed to add 'Access to medicines' to the foreshadowed item on 'Shortages of medicines and vaccines'.

WHA70 considered this item in May 2017. The item was initially deferred (see PSR7) to enable India and the US to sort out their differences. When the debate resumed (PSR8) India proposed that the subject be included on the agenda for EB142. Then followed a debate which was largely focused on shortages (PSR8 and PSR9) and which ended by noting the Secretariat report (A70/20) and agreeing to review at EB142.

EB142 commenced its discussion (meeting 6, here) with a draft decision proposed by Algeria, Brazil, Chile, Colombia, Costa Rica, the Netherlands and Portugal which proposed recommending that WHA71 decide to ask the DG to prepare a roadmap "outlining the programming of WHO's work on access to medicines and vaccines, including activities, actions and deliverables for the period 2019−2023" to be submitted to WHA72 through EB144 in Jan 2019. This decision was adopted as EB142(3) and in May 2018 WHA71 (in Decision WHA71(8)) likewise adopted this recommendation.

The draft roadmap was discussed at EB144 (see Watchers' notes) and a revised version of the draft roadmap has been prepared for consideration by the Health Assembly in the Annex to A72/17.

The commitments provided for in the draft Roadmap are structured around two strategic areas (first, quality safety and efficacy, and second, access). Eight 'activities' are identified across these two areas and a series of 'actions' under each of the eight 'activities' (with links to the GPW13). 'Deliverables' are identified under each of the 'actions' and milestones regarding the achievement of these deliverables are set out.

- Ensuring the quality, safety and efficacy of health products
    - Regulatory system strengthening;
        - Development and implementation of WHO technical guidelines, norms and standards for quality assurance and safety of health products
        - Support improvement of regulatory systems, promoting reliance and collaboration
        - Strengthen preparedness for entry of medicines, vaccines and other health products into countries experiencing a public health emergency or crisis
    - Assessment of the quality, safety and efficacy/performance of health products through prequalification;
        - Maintain and expand the prequalification service
    - Market surveillance of quality, safety and performance;
        - Support strengthening national capacity to ensure the quality, safety and efficacy of health products
- Improving equitable access to health products
    - Research and development that meets public health needs and improves access to health products;

        - Continue to set priorities for health research and development in areas of compelling health need;
        - Coordinated actions on health research and development
        - Support improved capacity for research and development and clinical trials in countries
    - Application and management of intellectual property to contribute to innovation and promote public health;
        - Foster innovation and access to health products by appropriate intellectual property rules and management
        - Provide technical support and capacity building
    - Evidence-based selection and fair and affordable pricing;
        - Support processes for evidence-based selection, including health technology assessment and their implementation
        - Encourage more transparent and better policies and actions to ensure fairer pricing and reduction of out-of-pocket payments
    - Procurement and supply chain management; and
        - Support collaborative approaches to strategic procurement of health products
        - Support countries in efficient procurement and supply chain management of health products
        - Improve capability and capacity for detecting, preventing and responding to shortages of medicines and vaccines
        - Support for adequate supply management and appropriate use of health products in emergencies and crisis situations
    - Appropriate prescribing, dispensing and rational use.
        - Interventions that improve use of health products
        - Support capacity for monitoring

Price transparency

One of the key 'activities in the draft road map is 'Evidence-based selection and fair and affordable pricing' with two actions: on health technology assessment and price transparency.

In February Italy tabled a draft resolution for consideration under this item on 'Improving the transparency of markets for drugs, vaccines and other health related technologies'. (See Italian draft Resolution on KEI website.)

18 Feb 2019: Health Policy Watch report (by Elaine Ruth Fletcher): Italy Floats Proposal For New Deal On Drug Pricing At World Health Assembly.

On the eve of WHO's second fair price forum (11-13 April) in Johannesburg, South Africa a group of 64 CSOs issued a joint statement: No "Fair Price" without access and transparency.

22 April 2019: TWN Info Service report: WHO: No "Fair Price" without access and transparency, say CSOs

By the end of April support for the Italian resolution appeared to be growing with Greece, Italy, Portugal, Slovenia, and Spain from the EU, as well as Malaysia, Serbia, South Africa, Turkey and Uganda signing up as co-sponsors. See Health Policy Watch report (30 April) by Elaine Ruth Fletcher): Drug Price Transparency: 10 Countries Back World Health Assembly Resolution

However, in closed-door informal consultations held on the proposal on 7 May 2019, Health Policy Watch (William New) reports a group of developed countries seeking to delay and water down the Italian proposal.

See also:

- 8 May 2019: Health Policy Watch report (by David Branigan): New Text Of Italian Transparency Proposal Shows North-South Divide Emerging

- 8 May 2019: PHARMALOT report (By ED SILVERMAN): Pharma pushes back against setting international standards for drug-pricing transparency

See the KEI table showing the proposed amendments to the original resolution coming out of the May 7 discussions.

On 8 May 2019 Jamie Love (of KEI) commented:

> *At a moment when the public is looking to their elected governments to address the crisis in the pricing of new drugs and other biomedical inventions, the World Health Organization has been asked to do something important: improve the transparency of markets for biomedical products and services. A resolution sent to governments by the WHO on April 29 that had ten co-sponsors from Europe, Asia and Africa set out an ambitious but practical agenda for making drug prices, R&D investments, patent landscapes and clinical trial outcomes progressively more transparent, and access to information more equal. At a May 7 negotiation on the text, a group of Northern European countries, lead by Germany, Denmark, Sweden and the UK, plus Australia, led an effort to gut the resolution, on behalf of drug companies who oppose transparency. The USA, Austria, Poland and Hungary also sought to eliminate key elements of the resolution. If the secrecy promoting changes are accepted, the public will continue to operate with less information about biomedical markets, and governments will have less power to curb high prices and reform R&D incentives.*

In a further comment on 10 May Jamie Love reports that R&D costs and government R&D subsidies are turning out to be the toughest part of negotiations or legislation on transparency.

However, he comments, the notion that one can't ask companies to disclosure specific clinical trial costs or government subsidies is naive. He cites further work by Luis Gil Abinader and Aimee Sixta of examples of disclosures companies make when they are important to investors.

- Examples of clinical trial costs disclosures
- Examples of tax credits disclosures
- Examples of government grants disclosures

More on KEI's work on transparency here: https://keionline.org/transparency.

Revised (10 May draft resolution), the outcome of intergovernmental consultations on 10 May here.

KEI comparison of April 29, May 7 and May 10 versions of the draft resolution.

SwissInfo (Jessica Davis Plüss, 190519): Push for drug pricing transparency strikes a nerve with industry

PHM Comment

Price transparency

PHM urges member states to support a strong version of the transparency resolution. Price transparency is a precondition for competition and market competition brings down prices.

It appears that the rich countries are working to ensure that unaffordable prices for medicines are to be maintained. It suggests that their support for the SDGs is somewhat hollow, including SDG3.8:

> *achieve universal health coverage (UHC), including financial risk protection, access to quality essential health care services, and access to safe, effective, quality, and affordable essential medicines and vaccines for all*

The draft road map

The draft roadmap is sensibly structured and brings together in a coherent way a wide range of programs and commitments which have previously been progressed separately. Secretariat staff are to be congratulated. However, there are some unfortunate omissions from the Roadmap which we list below. We

also note that there are no budget estimates associated with the deliverables and timelines. PHM has repeatedly criticised the donor chokehold on WHO programming, The freeze on ACs and the tight earmarking of donor funds means that some deliverables may be funded but others will be completely unfunded.

Omissions for MS consideration

Under **Regulatory systems strengthening** there are several references to quality standards and regulatory burden. What is not mentioned explicitly is the drive for the 'harmonisation' of standards through trade agreements associated with more and more demanding standards (as harmonised), beyond the requirements of safety, in order to exclude new market entrants, particularly those from low and middle income countries. This is a particular risk where private sector 'partners' from advanced manufacturing settings are involved in standard setting.

Under **Support improvement of regulatory systems, promoting reliance and collaboration**, there is no reference to investor state dispute settlement provisions in trade agreements and the possibility of these restricting the scope of regulation (there are six ISDS cases involving pharmaceutical companies listed in the UNCTAD ISDS database).

Under **Research and development for health products that meet public health needs** there is no explicit mention of the need for reliable information on the cost of pharmaceutical development including the relative roles of public funding and investor funding and the breakdown of funding across different stages/aspects of drug development.

In relation to this action we also note the deliverable which refers to **"transparency regarding the patent status of existing and new health technologies"**. This is a useful recommendation but MS must ensure that such transparency does not involve Patent Linkage provisions which are directed to harnessing the statutory powers of the NRA to police corporate IP claims. Breaches of IP are civil wrongs to be determined in civil jurisdiction. It is not the role of NRAs to police such claims.

Under **Provide technical support and capacity-building** we appreciate the reference to 'support for the consideration of public health implications when negotiating bilateral or multilateral trade agreements'. However, previous commitments regarding such technical support (eg WHA59.26) have gone nowhere for lack of funding and through powerful member states putting pressure on the Secretariat. This commitment illustrates the importance of WHO developing the necessary institutional capacity at all levels, including the country office.

Under **Encourage more transparent and better policies and actions to ensure fairer pricing and reduction of out-of-pocket payments** there is no mention of the role of publicly owned pharmaceutical manufacturing to promote competition and ensure greater transparency in relation to costs of production (in fact the Roadmap appears to equate 'the private sector' with 'manufacturing', see for eg para 45).

Under **Interventions that improve use of health products** there is no reference to the regulation of the marketing of health products although WHA60.16 (which urges MS to "to enact new, or enforce existing, legislation to ban inaccurate, misleading or unethical promotion of medicines, to monitor promotion of medicines") is listed in Appendix 1. We note that pharmaceutical companies defend their high profits in terms of the need to recoup expenditure on R&D. However, such companies spend much more on marketing than they do on R&D; marketing which often drives inappropriate use.

Likewise under this action there is no reference to provisions in economic integration agreements which require signatories to allow direct to consumer advertising notwithstanding the role of such marketing in driving inappropriate use.

The package is very weak in terms of rational use of medicines. If only a fraction of corporate marketing expenditure were to be redirected to supporting publicly accountable independent therapeutic advice platforms, including academic detailing, the rational and appropriate use of medicines would be greatly improved. Academic detailing is one of the most powerful tools for promoting rational use but is completely ignored under this action.

Unspecified targets and limited indicators

There is a very limited set of targets and indicators provided for (para 49), these being derived from the GPW13. The Roadmap will require more indicators to monitor all of the deliverables and milestones included in the Roadmap and in Section 4.3 of PB18-19 (see A70/7 from page 95).

"The implementation of the road map will be measured using these indicators and those that may be developed to complement them" (para 49) is very weak. WHO must identify the additional indicators that will be needed and develop appropriate guidance.

Lack of specification of the different roles of different levels within the Secretariat

The Roadmap provides no breakdown of what will be done in Geneva, the regional offices and the country offices nor how these different roles will be shaped. However, PB18-19 (in A70/7) does set out deliverables for country and regional offices.

Budget estimates

It is hard not to be cynical regarding the funding of this package.

The budget estimates in para 50 (from the PB18-19) project a total expenditure on this Roadmap of $84m per year which is ridiculously small compared with the magnitude of the problems and the strategies.

Gagnon and Lexin in 2008 cite estimates of US pharma expenditure on marketing in 2004 which range from $28-58 billion ($19 per person per year). The distribution of this expenditure includes 27.7% on detailing, 35.5% on samples, 7% on direct-to-consumer (DTC) advertising, 3.5% on meetings, 0.5% on emailing and clinical trials, 0.9% on journal advertising, and 25% on 'unmonitored promotion'.

The freeze on ACs and the tight earmarking of donor funds means that while some deliverables may be trickle funded others will be completely unfunded. In particular it is likely that virtually no funds will be available to support technical advice regarding trade negotiations or effective action on rational use and ethical promotion.

Powerful member states, led by the US, do not want WHO to be effective in promoting affordable reliable access to safe, effective and appropriately used medicines and vaccines if, in doing so, it undercuts the interests of the transnational pharmaceutical corporations.

The three countries which spoke against considering the recommendations of the HLP at EB140, the US, Switzerland and Japan, are the homes of some of the biggest pharmaceutical companies in the world. Not only are their governments harnessed to defend the interests of their corporations but these are some of the very few countries in the world which are net 'exporters' of intellectual property.

The 2006 Trade and health resolution (WHA59.26) provides a particularly egregious example of the determination of big pharma and its member state representatives to prevent WHO from implementing the mandates given by its governing bodies. See details in PHM's comment on this item at WHA71, here.

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

[This commentary prepared before publication of document A72/21 Add.1 scheduled for 17 May 2019; refer to www.who-track.phmovement.org/wha72 for updated commentary]

In focus

Pursuant to decision WHA70(10) (2017) and decision WHA71(11) (2018), A72/21 reports on the implementation of decision WHA 71 (11) (2018)

The various issues reported on in A72/21 have long and braided genealogies which need to be traced back, at least, to the 2016 PIP Review Group report.

Implementing the recommendations of the 2016 PIP Review Group

The report of the 2016 PIP Review Group was conveyed to the Assembly in A70/17.

In Decision WHA70(10), para 8(a) the DG was requested to take forward the recommendations of the Review Group.

In para 5 of A71/24 the Secretariat reported to WHA71 on progress on this request and in para 19(a) committed to completing the implementation of the recommendations of the 2016 PIP Review Group before WHA72. This recommendation was endorsed in Decision 71(11).

In A72/21, para 3, the Secretariat reports that this has been completed

Strengthening critical pandemic preparedness (and the Partnership Contribution Implementation Plan 2018–2023)

In Section 6.3 the PIP Review Group commented on the Partnership Contribution implementation (see findings 48- 55 of the PIP RG report).

In Decision WHA70(10), para 8(c) the DG was requested to "continue supporting the strengthening of regulatory capacities and carrying out burden-of-disease studies, which are fundamental foundations for pandemic preparedness" .

In paras 10-11 of A71/24 the Secretariat responded to this request highlighting the importance of the Partnership Contribution Implementation Plan 2018–2023 and in para 19(c)(i) undertook to continue the implementation of the Plan to this end. This undertaking was endorsed in Decision WHA71(11). In A72/21, para 4, the Secretariat reports on the implementation of the Partnership Contribution Implementation Plan 2018–2023.

Concluding Standard Material Transfer Agreements 2 and the collection of annual PIP Partnership Contributions

Key findings regarding SMTA2s are summarised in findings 34-42 of the Review Group report (in A70/17) leading to recommendations 18-22. Findings 43-45 deal with the collection of the PC leading to recommendations 23-24.

In Decision WHA70(10), para 5, the Assembly recognised the progress being made and in para 8(d) the DG was requested "to continue encouraging manufacturers and other relevant stakeholders to engage in PIP Framework efforts, including, where applicable, by entering into Standard Material Transfer Agreements 2 and making timely annual PIP Partnership Contributions". The Secretariat reported in A71/24 para 13, on progress regarding this request. In A71/24, para 19(c)(ii), the Secretariat undertook to conclude more SMTA2s. This was endorsed in WHA71(11), Annex (c)(ii). In A72/21, para 5, the DG refers to the reporting of PIP PCs in the June 30, 2018 Progress Report and through the Programme Budget portal.

Engagement with the secretariats of the Convention on Biological Diversity and other relevant international organizations

Findings 70-73 and recommendation 36 of the Review Group concern the relationship of the PIP Framework to the Nagoya Protocol of the CBD.

In WHA70(10), para (6) the Assembly recognized "the ongoing consultations and collaboration between WHO and the Secretariat of the Convention on Biological Diversity and other relevant international organizations" and in para 8(f) requested the DG to "continue consultations with the Secretariat of the Convention on Biological Diversity and other relevant international organizations, as appropriate".

In paras 17-18 of A71/24 the Secretariat advised the Assembly of progress in response to this request and in para 19(c)(iii) undertook to continue such engagement. This was endorsed by the Assembly in WHA71(11), Annex (c)(iii).

In para 6 of A72/21 the Secretariat reports that such engagement is ongoing (see report of June 2018 Consultation).

Implementing the recommendations of the External Auditor

The Review Group reported concerns and misunderstandings regarding the collection and use of partnership contributions (PCs), see pp 18-19 of A70/17. In para 8(e) of WHA70(10) the Assembly asked the Secretariat to organise an audit of the PCs.

In para 15 of A71/24 the Secretariat reported on the outcomes of this audit and in WHA71(11), Annex (d) the Assembly endorsed the undertaking of the Secretariat to implement the auditor's recommendations.

A72/21, para 7, reports that the recommendations of the Auditor have been implemented.

The sharing of seasonal influenza viruses and genetic sequence data

In Finding 11, the Review Group reported receiving wide-ranging views from key informants, including Member States, industry and civil society, on including seasonal influenza under the PIP Framework, with strong views both for and against, and judged that the implications of including seasonal influenza need to be studied further. Rec 3 was that "the Director-General should undertake a study to determine the implications and desirability of including seasonal influenza viruses in the PIP Framework". More detailed discussion in Section 3.2.1 from page 34.

The Review Group's summary of its findings and recommendations (12-17) regarding the sharing of GSD are quite specific.

In WHA70(10), para 8(b) the Assembly decided to request the DG:

> *regarding the PIP Framework Review Group's recommendations concerning seasonal influenza and genetic sequence data, to conduct a thorough and deliberative analysis of the issues raised, including the implications of pursuing or not pursuing possible approaches, relying on the 2016 PIP Framework Review and the expertise of the PIP Advisory Group, and transparent consultation of Member States and relevant stakeholders, including the Global Influenza Surveillance and Response System;*

In A71/24, para 19(b), the Secretariat advised the Assembly that "The Secretariat intends to complete the analysis in order to submit a comprehensive draft to the Seventy-second World Health Assembly through the Executive Board at its 144th session". This was endorsed in WHA71(11) and in EB144/23 (paras 7-24) the development of the draft analysis is described; the outcomes of the October 2018 consultation are summarised and the finalised analysis is referenced.

The issues associated with the possible inclusion of seasonal influenza under the PIP Framework were discussed by the PIP Framework Advisory Group from October 17-19, 2018. The Advisory Group's considerations and recommendations are contained in paras 43-52 of the report of the October meeting.

The Advisory Group's considerations regarding the treatment of genetic sequence data under the PIP Framework and related recommendations are contained in paras 53-65 of the report of the October meeting.

Draft decision

These matters were considered at EB144, informed by EB 144/23. At para 25 of EB 144/23 the Secretariat proposed a draft decision which would authorise it to continue to work on the uncertainties arising between the PIP framework and the Nagoya protocol and address some specific initiatives including: the search engine, the principle of acknowledgement, and the amended footnote (see Annex to EB144/23).

During the EB discussions, consensus could not be reached on the text of the draft decision. The board adopted a decision containing a draft decision (EB144(6)) which still contains lots of square brackets.

WHA 72/21 advises that a report on the intersessional consultations regarding the draft decision will be circulated before the Health Assembly meets (as document A72/21 Add.1). This report is scheduled to be published on 17th of May just three days before the opening of the Assembly.

It is evident from the brackets in EB144(6) that the following remain contentious:

- how to approach possible contradictions between the principle of access and benefit sharing in relation to seasonal influenza and the requirements of the Nagoya Protocol as implemented in domestic legislation;
- the development of a search engine developed to identify products that potentially have made use of genetic sequence data of influenza viruses with pandemic potential and have not been subject to the benefit sharing system (see para 32 of the PIP AG meeting on 8-10 Nov 2017 and para 85d(3) of the Dec 2018 Analysis);
- obligations on users of GSD data to acknowledge the providers of such data and to collaborate with such providers (see para 85c(4) of the Dec 2018 Analysis);
- how to respond to the loophole regarding the indirect use of PIP biological materials explored in para 23 of EB144/23 and the proposed amendment of Footnote 1 of Annex 2 to the PIP Framework set out in Annex to EB144/23.

Background

About genetic sequence data (GSD)

The issues of GSD has arisen in relation to the PIP Framework because of the expectation that for many applications (in the development of diagnostics, vaccines and therapeutics) GSD may come to replace dependence on biological samples. Under these circumstances secondary users drawing on published sequence data may be able to develop new products without any benefit sharing obligations.

This Scenario appears to have become a reality according to a recent report released through TWN. "Ebola: company avoids benefit-sharing obligation by using sequences" by Edward Hammond (TWN Briefing Paper 99) looks at the case of US pharmaceutical company Regeneron which developed an Ebola drug using the digital sequence information (DSI) of an Ebola virus strain from the clinical sample of a Guinean patient. While Regeneron has patented the drug and secured deals worth over $400 million for it, the company is under no obligation to share the resulting benefits with the country of origin of the virus strain, Guinea. This is because the DSI had been made available online by a research institute with “no strings attached” - highlighting a serious gap in efforts to ensure that the benefits arising from the use of genetic resources are equitably shared.

It is now widely recognised that the definition of biological materials under PIP needs to be revised to encompass GSD and new provisions are needed to ensure that secondary users are included in the benefit sharing obligation.

See more detail the discussion (from page 17) in the Dec 2018 revision of the Secretariat’s Analysis of GSD under PIP.

Manufacturers of diagnostics, vaccines and therapeutics are opposed to access and benefit sharing on the grounds that it involves additional transactions cost, may cause delays and may reduce profits. They are particularly opposed to including GSD in the definition of biological materials under PIP or under the Nagoya Protocol (see discussion in PHM comment on Item 12.10 on this agenda).

WHO’s May 2016 Statement on data sharing in the context of public health emergencies includes:

“WHO will advocate that pathogen genome sequences be made publicly available as rapidly as possible through relevant databases and that benefits arising out of the utilization of those sequences be shared equitably with the country from where the pathogen genome sequence originates.”

See also the four key principles developed by the PIP Advisory Group (para 53 from the October 2018 meeting):

1. There should be rapid sharing of high-quality GSD for timely risk assessment and response
2. There should be sustainable, public access to IVPP GSD
3. There should be fair and equitable sharing of benefits arising from the sharing of GSD
4. There should be acknowledgement of data providers and active collaboration between data providers and users.

About including seasonal influenza under the PIP Framework

Another parallel but related discussion concerns the possibility of including seasonal influenza under the PIP Framework.

This was considered by the PIP Advisory Group meeting in October 2018 but not recommended. See from para 43.

See Tracker links to previous discussions of the PIP Framework.

PHM Comment

Access and benefit sharing (ABS) are core principles.

Access to GSD must be subject to benefit sharing.

GSD must be included in biological materials in PIP.

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

We do not favour including PIP under NP (at this stage).

Multilateral mechanisms must be developed for ABS under NP. We commend the WHO Secretariat's indicative 'code of conduct'.

Ministries of Health must be closely involved in domestic and international debates around NP:

- argue for importance of ABS regarding all pathogens (IPP, seasonal influenza, emergency and other);
- argue for GSI to be encompassed; and
- argue for multilateral mechanisms.

12.2 Member State mechanism on substandard and falsified medical products

In focus

The sixth and seventh meetings of the Member State mechanism on substandard and falsified medical products were held in Geneva, Switzerland from 30 November to 1 December 2017, and on 29 and 30 November 2018 respectively. Updates on the implementation of the agreed list of prioritized activities for the period 2016–2017 were discussed, and a new list of prioritized activities for the period 2018−2019 was agreed. The report before the Assembly (A72/22) conveys the outcome documents from both meetings.

The reports of the sixth and seventh meetings need to be read with the Appendix to the sixth meeting open so that the references to 'activities' are given further context.

These two reports are on the WHA agenda because of a previous commitment to report to the Assembly every two years. They were noted by the EB in January.

Background

The Secretariat's Substandard and Falsified (SF) Medical Products page is here. This links to a range of publications and activities undertaken through the Secretariat including regulatory strengthening and capacity building.

The index page to the meetings of the member state mechanism (MSM) on substandard and falsified medical products is here. From here are linked the agendas, papers and reports from all of the 7 MSM meetings.

See Tracker links for previous governing body discussions of SF medical products. See in particular the Background note to the PHM comment on Item 8.6 at EB140 which explains the origins of the MSM and sets out the timelines regarding this issue.

See also Item 13.6 at WHA70 (2017) at which time the terminology issue was resolved with SSFFCMP replaced by Substandard and Falsified and 'counterfeit' was finally dropped.

PHM Comment

The circulation of substandard medicines is driven by supply side factors (including access to technology for domestic production and shortfalls in regulation) and demand side factors (in particular high prices for high quality imported medicines). The circulation of falsified medicines also reflect regulatory failure and high prices.

Most of the issues associated with domestic production, regulatory strengthening and high prices are listed for attention under the Roadmap for access (A72/17) being considered under Item 11.7. However, as we have noted in our comment on Item 11.7, the resources available are quite inadequate to effectively address these challenges.

Transit

The issue of transit, the role of customs authorities in policing the trade in substandard and falsified medicines, is not mentioned in A72/17 but should be encompassed by the commitment to regulatory strengthening. The discussion paper on transit produced for the MSM by the WHO Secretariat (A/SMS/7/5) highlights the significance of the risk indicators used by customs authorities to determine whether to inspect commodities crossing borders. It appears that alerts from regulatory authorities or industry stakeholders play a key role in prompting customs intervention.

The pilot questionnaire reported in the transit report to the MSM suggests that, at least in Africa, the national medicines regulatory authorities are not working very closely with customs authorities to interdict quality compromised products crossing borders. Clearly the cooperation between NMRAs and customs authorities is an issue which needs to be on the regulatory strengthening agenda.

Industry stakeholders may also be alert to the circulation of substandard or falsified medical products but they may be more concerned with IP status than compromised quality as the scandals associated with EU customs authorities interdicting pharmaceuticals in transit through European ports illustrates. Seizures of quality pharmaceuticals, approved in both source and destination countries, constitute a significant barrier to access.

The intersections of IP regulation and the regulation of quality, safety and efficaciousness

IP issues impact on public health concerns in many ways including price, R&D, access, supply chain issues, local production as well as customs practices.

The discussion paper on transit takes an extreme 'hands-off' approach to the intersection of intellectual property and public health concerns: "This document is not intended to affect intellectual property legislation, and it is not derived from a detailed examination of such legislation."

However, the pharmaceutical industry has a deeply entrenched interest in prosecuting an extreme IP agenda in relation to pharmaceutical R&D, pricing, supply chain management, and the regulation of quality, safety and efficacy.

The IMPACT story (Shashikant 2010) tells of the attempt by Big Pharma, supported by its nation-state sponsors, to deploy WHO's authority to support the policing of IP ownership claims. The deliberate conflation of 'counterfeit' with quality and safety has been a central ploy in this strategy. This story is told in more detail here. A similar agenda was being prosecuted at the same time (in secret) under the Anti-Counterfeiting Trade Agreement (MSF Access, 2012). It was resistance to this ploy that led to the MSM being established and to WHO adopting the new definitions of substandard and falsified medical products.

Big Pharma has also sought to deploy the regulatory powers of national medicines regulatory authorities in the policing of IP ownership claims as part of marketing approval. One strategy has been to include

provisions for patent linkage in trade agreements (see Townsend, Gleeson & Lopert 2016 on patent linkage in the RCEP agreement). An alternative strategy has been to lobby national governments with a view to including patent linkage provisions in national regulatory law (see Kenya Counterfeit Act for a case study of this strategy).

At a more macro level it is useful to recognise 'forum shifting' as another strategy which Big Pharma has deployed to advance its IP objectives. Drahos (2002) describes how Big Pharma, led by Pfizer, moved its campaign around IP reform from WIPO (where developing countries were represented) to the Uruguay Round in which the large industrial countries held sway and which led in 1994 to the TRIPS Agreement. After the IMPACT strategy was exposed in 2008 and the MSM was established (in 2012) to progress WHO's consideration of substandard and falsified medicines, the focus of Pharma lobbying moved to the large global health agencies, in particular, the Global Fund for AIDS, TB and Malaria.

In 2012, in close association with USAID, the Global Fund established the Joint Interagency Task Force to "[safeguard] the delivery of quality medicines for major donor organizations and protecting public health by identifying falsified medicines in countries where they appear" (Cinnamond & Woods, 2015). " A core focus area of the Global Fund component of JIATF (GF-JIATF) is its National Engagement Strategy (NES), which serves as a launch pad to develop partnerships and provide training and logistical support to partners within a country's national drug regulatory and law enforcement community."

Also sponsored by the GF is the 'Global Steering Committee' for quality assurance of health products which includes a number of global health partnerships, US government agencies and the World Bank and the WHO. The GSC has established five working groups: 1) supporting national medicines regulatory authorities, drug quality and supply chain authority; 2) data gathering, reporting, sharing, and analysis; 3) information dissemination and public awareness; 4) enforcement; and 5) financing of GSC initiatives.

The Global Steering Committee established a 'Private Sector Advisory Group' in 2016 comprising 'representatives of research-based and generic pharmaceutical manufacturers and the International Federation of Pharmaceutical Manufacturing Associations'.

Reports from the WHO Secretariat on WHO's involvement in the Global Steering Committee have been provided to the MSM since 2015 (see A/MSM/4/8 (2015), A/MSM/5/3 (2016), para 13 of the report of the 6th meeting of the MSM and paras 12-13 of the 7th meeting report. See the TWN Report of November 2015.

It appears that the focus of Pharma's campaign to influence NMRAs shifted from WHO to the GF after the IMPACT scandal and the establishment of the MSM. Clearly the GSC's private sector partners would have much more access to NMRAs with the GSC than via the MSM.

WHO needs to take a much more pro-active stance in relation to the impact of IP regulation and industry lobbying on access to quality, safe and effective medicines. Member states need to remove the chokehold around WHO's finances so it can fulfill its mandate properly.

12.3 Human resources for health

In focus

Pursuant to resolution WHA63.16 (2010) and decision WHA68(11) (2015) document A72/23 reports on the aggregate findings across WHO regions from the third round of national reporting on implementation of the WHO Global Code of Practice on the International Recruitment of Health Personnel.

Report A72/24 summarizes progress made in the implementation of the WHO Global Strategy on Human Resources for Health: Workforce 2030, in line with the request made by the Health Assembly in resolution WHA69.19 (2016). The report also provides details of progress made in respect of the following resolutions: WHA64.6 (2011) on health workforce strengthening; WHA64.7 (2011) on strengthening nursing and midwifery; and WHA70.6 (2017) on human resources for health and implementation of the outcomes of the United Nations' High-Level Commission on Health Employment and Economic Growth.

Background

Tracker links to previous EB/WHA discussions of human resources for health.

PHM Comment

Lack of trained health workers with appropriate supports is a fundamental obstacle to accessing decent health care for many millions of people.

The impact of inter-governmental organisations, conferences, agreements and statements is limited:

- Better data is good; clearly the situation is complex.
- Technical assistance (data, policy, bilateral agreements) is useful at the margins.
- Rhetoric about ethical recruitment may have a marginal effect.
- Raising awareness about countries which have critical workforce shortages may have a marginal effect.

However, health system strengthening at the local and national levels, including appropriate training and decent secure jobs, is fundamental. This depends on governance capacity and resources, both of which are held hostage to the pressures and imbalances of neoliberal globalization.

This may be why many countries, particularly in the Africa region have not designated national authorities in relation to the Code and many countries, including several high income recipient countries, had not submitted reports on Code implementation by March 2019.

The Code

The third round of national reporting reveals no significant increase since 2016 in the number of designated national authorities; a small increase in the number of national authorities actually reporting to the Secretariat; some improvement in the availability of data, including data on formal international arrangements. The report does not confirm that the 77 separate bilateral multilateral and regional arrangements do significantly progress the objectives of the Code.

The creation of the International Platform on Health Worker Mobility and the Multi-partner Trust Fund our forward steps.

A72/23 also reports on the planned methodology for the second review of the Code's relevance and effectiveness as required in the Code. PHM urges member states to ensure that the review of relevance and effectiveness has regard to alternative strategies and structures for promoting more equitable health worker mobility including compensation.

PHM accepts that health worker migration is more complex than simply "brain drain" but there are still gross differences between health worker density in the African region and in the European region which point to the net flow of value which is associated with South North migration. there is still an urgent need to estimate the net costs and the net gains associated with migration trends and to explore the need for the payment of compensation to be included in international agreements.

We appreciate the inclusion of some cost data in the national health workforce accounts model; we urge the Secretariat to explore methodologies for estimating the flows of value, in financial terms, associated with health worker migration.

The Global Strategy

A72/24 reports on the implementation of the Global Strategy on Human Resources for Health: Workforce 2030. There has been a great deal of the very useful activity which is appreciated. The development of the national health workforce accounts model is a particularly useful initiative.

It is a weakness of the strategy, and of this report, that there is no disaggregation between public employment and private practice; a health worker in public employment is not the same as a private practitioner; she is more accountable with respect to quality and efficiency and more likely to be addressing real needs. We note that some data on sector of employment would be collected in the national health

workforce accounts model. We urge the Secretariat to explore methodologies for processing these data in ways that can contribute usefully to health system strengthening.

It is not clear from the material published around national health workforce accounts whether the data collected will enable analyses of (i) employment in medical tourism; and (ii) health worker training for remittance revenues. Collecting such data and undertaking such analyses would be very useful in policy terms.

Donor dependence

Good work is being done. However it clearly depends heavily on donor funding. It appears that fundraising has become a responsibility of program managers which has a seriously fragmenting effect on the whole organisation as managers are forced to compete with each other for donor attention and are under strong pressure to self-censure in applying for funds and carrying out their analyses and policy work.

WHO is rhetoric in relation to UHC and health workforce development appears to be quite agnostic regarding any differences (in terms of quality, efficiency, and equity) between public sector health care provision and private practice. This appears to reflect the power of donor preference.

12.4 Promoting the health of refugees and migrants

In focus

Pursuant to decision EB140(9) (2017) and resolution WHA70.15 (2017), the report A72/25 provides an update on the status of the proposed global action plan on the health of refugees and migrants. A previous version of this report was considered at EB144 and has been 'extensively revised' following that discussion.

In para 36 the Assembly is invited to note the global action plan; to urge member states to report back on the action they take relating to the plan; and to ask the DG for a progress report in two years time.

Background

Tracker links to previous discussions of refugees and migrants. See in particular A70/24 which sets out a framework of priorities and guiding principles. See also Watchers' notes from EB144.

See also the summary reports of regional committee discussions of this item from paras 16-19 of EB144/3.

See the 2016 New York Declaration for Refugees and Migrants and the 2018 report of UN Secretary General on International migration and development (A/73/286).

See UN index page for the Global Compact on Migration (commissioned Sept 2016; finalised July 2018; adopted December 2018).

PHM Comment

There has been a huge increase in migration and asylum seeking over the last two decades. There are many causes for this including intolerable conflict and deprivation as well as government policies and individual aspiration. Likewise there are many consequences including disease, injury, suffering and death as well as benefits for individuals, families and societies.

PHM commends the resolution of WHA70.15 calling for the Secretariat to develop a global action plan on the health of refugees and migrants.

We note that action on the health of migrants, asylum seekers and refugees should be aligned with wider action such as that called for in the 2016 New York Declaration for Refugees and Migrants and the Global Compact for Safe, Orderly and Regular Migration (July 2018).

The draft global action plan presented in A72/25 is structured around six priorities, each of which comprises a general objective and a set of options for Secretariat action.

There is nothing in this draft which commits member states to any action or which might hold member states accountable with respect to previous commitments or established international norms. This is quite unusual. There was nothing in resolution WHA70.15 which required the draft to be limited to Secretariat action only and, given the broad commitments which most member states have agreed to through the New York Declaration and the Global Compact, the concept of including member state commitments and accountabilities should not have been ignored thus.

The six priorities which are to be addressed under this plan are carefully restricted to the health of people who are migrants or refugees. Within this domain the priorities, objectives and options for Secretariat action are all sensible and constructive. However, the weaknesses in this plan lie in what has been excluded.

Footnote 3 on page 1 suggests that the Secretariat has been subject to some serious bullying in the development of this plan:

> *For purposes of clarity, this global action plan on the health of refugees and migrants is voluntary; its acceptance by the Health Assembly would not change the voluntary nature of the plan. The plan is intended solely for the Secretariat and will not have any financial implications for Member States. The Secretariat will provide support to Member States only upon request and in accordance with national legislation and country contexts.*

The content of the plan has been strictly circumscribed to exclude reference to the social determination of migration and asylum seeking. Priority Action 4 takes an extremely restricted view of the concept of social determinants of health: "*Ensure that the social determinants affecting refugees' and migrants' health are addressed through joint action and coherent multisectoral public health policy responses*". This appears to exclude the social determinants which drive asylum seeking and which lie behind the present health challenges faced by refugees and migrants. This is analogous to emergency department doctors who provide excellent care for brutalised women but do not inquire about the source of the violence.

This exclusion is even more regrettable in view of Objective 2 of the Global Compact which commits signatories to minimising "the adverse drivers and structural factors that compel people to leave their country of origin. We commit to create conducive political, economic, social and environmental conditions for people to lead peaceful, productive and sustainable lives in their own country and to fulfil their personal aspirations, while ensuring that desperation and deteriorating environments do not compel them to seek a livelihood elsewhere through irregular migration."

If the social determinants of health means anything it requires that the health authorities document the role of such 'adverse drivers and structural factors' in harming people's health.

It is bizarre to recognise the dramatic increase in the number of migrants and asylum seekers over the last two decades and ignore:

- the roots of war and communal violence which contribute to driving migration and asylum seeking;
- the roots of economic stagnation and widening inequality which through poverty and contribute to driving migration;
- global imperialism under which big powers can invade smaller countries with impunity;
- neoliberal globalisation always teetering on the brink of collapse but stabilising itself through further immiseration of the 'reserve armies of the poor'; maintained to keep labour costs low and transfer production to lower wage platforms if labour costs rise; and
- a 'free trade' regime which promotes free movement of all of the inputs to production except labour.

The need for provisions in the global plan directed to strengthening member state accountability in relation to the drivers as well as the management of migration and asylum seeking is well illustrated by the several countries which have refused to adopt the (non-binding) Global Compact, perhaps because of its condemnation of xenophobia and extended immigration detention.

Several of the countries refusing to adopt the Global Compact may have reason to object to Objective 17, under which signatories "commit to eliminate all forms of discrimination, condemn and counter

expressions, acts and manifestations of racism, racial discrimination, violence, xenophobia and related intolerance against all migrants".

Australia which is notorious for its use of immigration detention for deterrence is one of those countries which has refused to adopt the Compact, perhaps because of Objective 13 "Use immigration detention only as a measure of last resort and work towards alternatives" and para 29(c):

> *Review and revise relevant legislation, policies and practices related to immigration detention to ensure that migrants are not detained arbitrarily, that decisions to detain are based on law, are proportionate, have a legitimate purpose, and are taken on an individual basis, in full compliance with due process and procedural safeguards, and that immigration detention is not promoted as a deterrent or used as a form of cruel, inhumane or degrading treatment to migrants, in accordance with international human rights law*

Hungary spoke sharply against the Global Compact during the debate at EB144.

The prevailing global regime of neoliberal transnational capitalism is economically unstable with the recurring threat of crisis and widening economic inequality. It is destabilising the human environment, including global warming, and is generating economic, food and personal insecurity for billions. One of the consequences is mass migration and asylum seeking.

As part of managing the instabilities of globalised capitalism ruling elites in many countries are seeking to sustain their privilege by encouraging fear and xenophobia among those who feel threatened by migration.

These dynamics contribute to the social determination of migration and asylum seeking but are rendered invisible in this global action plan.

12.5 Patient safety

In focus

Global action on patient safety

Patient safety is a critical global public health objective. An inadmissible number of patients are harmed or die each year as a result of unsafe care, placing a significant burden on health systems across the world and jeopardizing progress towards universal health coverage. At the request of Member States, the Director-General has provided this (A72/26) report outlining the burden of patient harm, global efforts made to date in support of patient safety and key global action areas and strategies for taking this work forward.

The Executive Board considered an earlier version of this report in January and recommended that the Assembly adopt the draft resolution contained in EB144.R12.

Water, sanitation and hygiene in health care facilities

The first-ever global assessment on this matter, conducted in 2015 by WHO and UNICEF, found that nearly 40% of facilities lack water, 20% are without sanitation, and 35% do not have any hand hygiene materials. This situation undermines universal health coverage, quality care initiatives, and infection prevention and control efforts. It also contributes to the spread of antimicrobial resistance. In response, launching the International Decade for Action "Water for Sustainable Development" 2018–2028, the United Nations Secretary-General issued "a global call to action on water, sanitation and hygiene" in all health care facilities in March 2018. In light of this background, and at the request of a Member State, the Director-General has provided this report on the subject (A72/27).

The Executive Board considered an earlier version of this report in January and recommended that the Assembly adopt the draft resolution contained in EB144.R5.

Background

See WHO website index pages to Patient Safety and Water, Sanitation Hygiene.

WHO Watch record of debate at EB144.

PHM Comment

Patient safety

The data are worrying; both the morbidity and the costs. Undoubtedly the kinds of errors and harms listed in para 4 are common in all health care systems. Patient safety is a major issue globally.

However, there is very little here about causation and nothing about one of the most salient causes in L&MICs which is lack of resources (supplies, staff, electricity, maintenance, etc).

The document affirms that patient safety needs to be addressed as a system issue in the context of local realities. However, the discussion of strategies for improving patient safety does not address health care financing arrangements nor the anarchy of privatised medical and hospital services in many countries.

Patient safety and quality of care

The focus of this report and the proposed resolution is exclusively on 'patient safety' in contrast to the discussion of patient safety and quality of care in Output 4.2.3 ('Countries enabled to improve patient safety and quality of services, and patient empowerment within the context of universal health coverage') in PB18-19 (A70/7).

The Secretariat deliverables listed under this Output in PB18-19 are more coherent and comprehensive than the initiatives proposed in EB144.R12 and specify deliverables at the country, regional and headquarters levels.

It is not clear why the Secretariat chose to separate patient safety from quality of health care for the purposes of this report.

The proposed resolution relies substantially on yet another world health day notwithstanding the questions being asked about the range of such days, weeks and years and their effectiveness.

There is nothing here about the challenges of regulating safety and quality in private sector facilities. There is nothing here about measurement or accountability.

Review of WHO's work on patient safety and quality of care needed

There is quite a lot in A72/26 about what the WHO Secretariat has been doing but, notwithstanding the acknowledgement that not much has changed in the last 15 years, there does not seem to have been any independent review provided to the governing bodies regarding the strategic directions of the Secretariat's work in this domain.

Some of the questions which a review of this programme might ask:

- Why has patient safety been so sharply separated from questions of quality of care? These are not the same but closely overlap in causation and strategy.
- Why is patient safety being so sharply compartmentalised away from broader questions of health systems strengthening? One of the core principles of patient safety is 'institutional resilience'; recognising that humans make mistakes but safe (resilient) institutions prevent those mistakes from causing harm. Resilience in low resource settings is a particular challenge which deserves more attention. Clinical governance, institutional resilience, a culture of caring, respect for professionalism and building trust are all challenges of health system strengthening generally.
- Why is there no discussion of various approaches to 'clinical governance' as a system wide approach to measurement and accountability? How can the principle of clinical governance be realised under different health care financing arrangements, in particular in chaotic privatised

systems. How can health care financing arrangements be leveraged to promote quality and safety in low resource settings?

- To what extent is the isolationism of the patient safety program a function of its funding. Who funds WHO's patient safety work and are those funds tightly earmarked and if so do donor preferences influence the orientation and approach adopted by the Secretariat?

PHM has long worried that the slogan of UHC was introduced to avoid seriously engaging with the challenges of health system strengthening because of the sensitivity of organisational structures and health care financing. Addressing patient safety separately from quality of care and health system strengthening may reflect the same caution.

PHM urges MSs to request an independent review of the Secretariat's work in patient safety and quality of care within the context of the broader challenges of health system design, health care financing and health system strengthening.

WASH in health care facilities

The prevalence of health care facilities without water, adequate sanitation, capacity for hand hygiene, or safe management of waste is dreadful. The consequent morbidity (and loss of trust) is huge. As A72/27 comments (para 2), "These failings undermine the promise of universal health coverage."

The barriers to full provision of WASH capabilities and practices in health care facilities are significant: overburdened staff, low expectations, bureaucratic backwaters, budget neglect and lack of data.

Experience shows that incremental change is possible and builds enthusiasm for further change. Political and managerial leadership are critical.

WHO is promoting improved data collections, technical support at the country level, encouragement of intersectoral collaboration at the country level and the practice of such collaboration within the Secretariat and across the UN system.

The Health Assembly is invited to adopt the draft resolution contained in EB144.R5 which identifies a range of useful initiatives for member states and for the Secretariat.

Mainstreaming safety and quality into health system strengthening

The mainstreaming of patient safety and quality, including WASH capacities and practices, into health system strengthening generally is critical. When health systems improve, they do so incrementally. Opportunities arise unpredictably in different locations, at different times and regarding different issues. Ensuring that such opportunities are grasped calls for leadership (technical, managerial, political), ongoing broadly based policy dialogue about priorities, and a movement for change, encompassing both the workforce and the wider community.

PHM urges MSs to ensure that future directions regarding quality and patient safety, including WASH capabilities and practices, are embedded in a broader set of strategies directed to driving the dynamics of health system strengthening, including supporting the role of civil society in these processes.

12.6 Smallpox eradication: destruction of variola virus stocks

In focus

A72/28 provides a brief background to governing body discussions around the destruction of variola virus stocks.

In decision WHA64(11) (2011) the Sixty-fourth World Health Assembly reaffirmed earlier decisions (resolutions WHA49.10'(1996) and WHA52.10 (1999)) that the remaining stocks of variola virus should be destroyed.

Enacting this decision has been deferred on the grounds that the virus is still required for research into better vaccines, diagnostics and therapeutic medicines. Some members of the Advisory Committee are of the view that live virus is still needed for the development of diagnostics and medicines.

The report also reviews current advice around the use of synthetic biology technologies to create smallpox virus from the known DNA sequence.

Background

Official WHO publications on smallpox here.

Tracker links to previous discussions of Smallpox

PHM Comment

PHM believes that all remaining stocks of variola virus should be destroyed as soon as possible. We note the view of some on the Advisory Committee that further work on diagnostics and therapeutic agents justifies the continuing existence of the stocks. We believe that the risk of accidental release outweighs the putative benefits of improved diagnostics and therapeutics.

The destruction of the two remaining stockpiles would not affect the risk of bioterrorism using synthetic virus or the accidental release of synthetic virus. Security in relation to these risks depends on strict regulation of laboratories with such capability by national authorities. Technical guidance through WHO will remain critical in this work.

The final risk, that of weaponisation of smallpox through diversion from existing stocks of virus, would presumably be undertaken in deep secrecy and away from the various committees and inspectorates operating through WHO. Such diversion could have already been effected under this scenario, in which case it would not be affected by the destruction of the officially known stockpiles. However, on the assumption that diversion has not taken place yet, the sooner the official destruction takes place the better.

12.7 Eleventh revision of the International Classification of Diseases

In focus

The Secretariat report (A72/29) provides:

- an introduction to ICD and its history;
- an overview of the processes involved in the development of ICD11, including preparation for implementation;
- an overview of the review and consultation processes involved in guiding the finalisation of ICD11;
- an overview of the general characteristics and content of ICD11, including some specific issues;
- a note on WHO's family of classifications and the relations between ICD11 and the other classifications;
- an outline of provisions for implementation; and
- for further updating and revision.

The Health Assembly is invited to note this report.

A draft resolution was included in the version of this report which was considered by EB144 but agreement could not be reached on a consensus version of this resolution during the EB. Following further intersessional consultation an agreed draft resolution has been finalised and is conveyed to the Health Assembly in A72/29 Add.1.

Background

A72/29 provides useful background information.

See also WHO's 'health topic' on ICD.

Tracker links to previous discussions of ICD11

PHM Comment

Bringing ICD11 to this stage has been a huge undertaking. The updated classification and the upgraded functionalities will add significantly to the quality of data available for planning, accountability and research.

PHM extends the warmest congratulations and thanks to the Secretariat and all of those who have been involved and urges MSs to adopt the proposed resolution.

12.8 Global Strategy for Women's, Children's and Adolescents' Health (2016–2030)

In focus

A72/30 reports on progress (and lack of it) regarding women's, children's and adolescents' health; reviews relevant WHO activities, and comments on cross cutting issues including UHC; multisectoral action, rights and equity; and monitoring and accountability.

This item started out as a Progress Report regarding WHA58.31 but at EB144 it was decided to list it as an item for discussion (Item 12.8) and to include reviews of progress regarding WHA67.10 and WHA69.2

Background

Tracker links to previous discussions of GSWCAH

PHM Comment

WHO is doing good work across a wide range of technical issues but the overall picture which emerges from this report, particularly in Sub-Saharan Africa and South Asia, is quite depressing.

Stagnant indicators (such as maternal mortality, stunting, access to clean water) are framed by weak health systems, shortfalls in other government services and programs, failing food systems, widespread poverty, patriarchy, climate change and conflict and instability.

The kinds of technical programs reported in A72/30 need to be matched by macroeconomic and political reforms to address the macro factors (in particular neoliberal globalisation, patriarchy and imperialism) while in parallel progressing the technical issues.

The diplomatic norms which govern the debate at the Health Assembly preclude the naming of these macro factors and thereby contribute to keeping them obscured.

12.9 Emergency and trauma care

In focus

Document A72/31:

- sets out a number of key principles for strengthening emergency care systems;

- recommends key activities for member states to undertake with a view to strengthening emergency care systems;
- lists some common barriers to more effective emergency care in low and middle income countries;
- reviews briefly some of the main resources, programs and initiatives undertaken by the Secretariat to promote more effective emergency care systems.

Background

See WHO's Emergency and Trauma Care webpages.

See tracker links to previous discussions of emergency surgical care

PHM Comment

The disease burden associated with lack of timely access to quality emergency care is clearly huge. This disease burden is highly inequitably distributed. Some of the barriers can be addressed through better organisation and governance of service systems and workforce development. Others will be more dependent on resources.

Member states are urged to implement the activities recommended in para 13.

The resources and initiatives on offer through the Secretariat are practical and strategic. However, it is clear that the Secretariat's capacity, at country and regional offices as well as at headquarters is severely limited by lack of resources.

'Improved pre-hospital and facility-based emergency care systems to address injury' is Output 2.3.4 in PB18-19. The total expenditure estimate for Category 2.3, 'Violence and injuries' (of which emergency care is only part) is only $30m for the biennium (Table 5).

This is a clear reflection of the continuing freeze on assessed contributions and the tight earmarking of voluntary contributions. The donor chokehold hobbles WHO's capacity to deliver.

12.10 The public health implications of implementation of the Nagoya Protocol

In focus

This agenda item originated with a suggestion from the October 2018 meeting of the PIP Advisory Group (para 52, here) to the DG that he suggest to EB144 that an item on 'The public health implications of implementation of the Nagoya Protocol' be included on the provisional agenda of the Seventy-Second World Health Assembly.

The PIP Advisory Group was concerned that the implementation of Nagoya was affecting the sharing of seasonal influenza virus. The Advisory Group was concerned that ministers of health, concerned about public health implications of Nagoya, should be more involved in national and international discussions about mechanisms for implementing Nagoya.

Several member states were critical of the PIP Advisory Group for over-stepping its mandate (which is focused on influenza viruses with pandemic potential) and of the Secretariat and officers of the Board for linking the proposed item on the Nagoya Protocol as a footnote to the item regarding PIP. See also WHO Watchers' notes of debate over this proposal at EB144.

However, the Board agreed to include this item on the provisional agenda for WHA72 and the Secretariat has prepared A72/32 to inform this discussion.

A72/32 refers to a number of issues which need attention and refers to previous documents relating to those issues.

1. The timely sharing of pathogens and equitable access to the benefits (diagnostics, vaccines, therapeutics) arising from such sharing. The Nagoya Protocol supports these objectives and provides opportunities to further them.
2. Pursuing such opportunities involves negotiating around intellectual property issues, the sharing and management of genetic sequence data, research and publication of results, traceability, biosecurity, monetary and non-monetary benefit sharing, as well as international and domestic law and process matters.
3. Para 12: To ensure that access and benefit-sharing legislation and implementation plans take into account the imperatives of public health, Member States should take proactive steps to ensure that health ministries are represented and engaged in discussions and planning.
4. The WHO Secretariat is ready to explore ... possible options, including codes of conduct, guidelines and best practices, and global multilateral mechanisms, for pathogen access and benefit sharing (ABS).

Background

About the Nagoya Protocol

The Nagoya Protocol index page on the CBD website provides links to the full text of the Protocol, to recent meetings and documents .

The background document produced in 2013 by the Berne Declaration and a number of other civil society organisation provides useful introduction to the underlying principles of access and benefit sharing and to the specific sections of the Protocol.

EB140/15 provides an overview of the WHO Secretariat 2016 study of the implementation of the Nagoya Protocol for pathogen sharing and public health implications (in full here).

WHO workshop report: Facilitating Access and Benefit-Sharing (ABS) for Pathogens to Support Public Health, Sept 2018 provides a very useful review of the importance of ABS in the context of public health surveillance, preparedness and response.

About genetic sequence data (GSD)

The status of genetic sequence information (GSI in CBD parlance) is contentious in relation to the Nagoya Protocol. See for example the collapse of consensus in July 2018 in Montreal (reported in SUNS #8725) and further comment 16 Nov 2018.

"Ebola: company avoids benefit-sharing obligation by using sequences" by Edward Hammond (TWN Briefing Paper 99) looks at the case of US pharmaceutical company Regeneron which developed an Ebola drug using the digital sequence information (DSI) of an Ebola virus strain from the clinical sample of a Guinean patient. While Regeneron has patented the drug and secured deals worth over $400 million for it, the company is under no obligation to share the resulting benefits with the country of origin of the virus strain, Guinea. This is because the DSI had been made available online by a research institute with “no strings attached” - highlighting a serious gap in efforts to ensure that the benefits arising from the use of genetic resources are equitably shared.

See also PHM comment on Item 12.1 regarding the PIP framework where there is an extended discussion of genetic sequence data.

About national and/or multilateral compliance mechanisms under Nagoya

WHO’s 2016 study of the public health implications of the NP describes the two basic requirements governing access and benefit sharing under the NP as prior informed consent (PIC) and mutually agreed terms (MAT) (page13). How these basic requirements operate depends on how they are constructed in domestic legislation.

A number of contributors to the 2016 study expressed concern that, as access and benefit sharing principles were more widely implemented, the transaction costs (of negotiating PIC and MAT bilaterally in relation to each transfer) might grow considerably, given the different forms domestic enabling legislation might take.

The provisions of the PIP Framework illustrates an international instrument under which the compliance provisions were negotiated multilaterally and which are managed centrally which clearly reduces the compliance costs.

WHO's January 2019 consultation document, on a possible code of conduct for open and timely sharing of pathogen genetic sequence data during outbreaks of infectious disease, could provide the basis for a wider discussion of multilateral mechanisms for access and benefit sharing regarding seasonal influenza and other pathogens as well as pandemic influenza and other epidemic pathogens. (This document was produced under the emergency preparedness mandate covering the R&D Blueprint for action to prevent epidemics, see A70/10 and Blueprint index page).

See also reference (in the Dec 2018 revised Analysis) to the use of Article 10 to developing an global multilateral benefit sharing mechanism.

About recognising the PIP Framework under the Nagoya Protocol

Some concern has been expressed regarding the relationships between the PIP Framework and the NP. One scenario might involve conflicts between domestic legislation under the Nagoya Protocol and the requirements of the PIP Framework, for example if PIP were to include GSD but domestic legislation under NP excluded it.

Because of this possibility there has been some discussion of recognising PIP under NP.

Article 4.4 of the NP provides:

> *Where a specialized international access and benefit-sharing instrument applies that is consistent with and does not run counter to the objectives of the CBD and the Nagoya Protocol, the Nagoya Protocol does not apply for the Party or Parties to the specialized instrument in respect of the specific genetic resource covered by and for the purpose of the specialized instrument.*

The Secretariat's Dec 2018 Revised Analysis (from para 49) explores the pros and cons of harmonising the Global Influenza Surveillance and Response System (GISRS) with the NP.

There is only limited enthusiasm for this option among member states.

PHM Comment

Access and benefit sharing (ABS) are core principles.

Access to/GIS must be subject to benefit sharing.

GSI must be included as genetic resources under NP.

We do not favour including PIP under NP (at this stage).

Multilateral mechanisms must be developed for ABS under NP. We commend the WHO Secretariat's indicative 'code of conduct'.

Ministries of Health must be closely involved in domestic and international debates around NP:

- argue for importance of ABS regarding all pathogens (IPP, seasonal influenza, emergency and other);
- argue for GSI to be encompassed; and
- argue for multilateral mechanisms.

14. Health conditions in the occupied Palestinian territory, including East Jerusalem, and in the occupied Syrian Golan

In focus

A72/33 reports to the Assembly on:

- WHO's involvement in providing support and technical assistance to the population of the occupied Palestinian territory including East Jerusalem and the occupied Syrian Golan;
- the health conditions in the occupied Palestinian territories; and
- progress on the recommendations included in A71/27 and noted in WHA71(10).

Background

Tracker links to previous discussions of Palestine.

PHM Comment

The situation described in A72/33 is a tragedy. PHM has repeatedly expressed its deep solidarity with the struggle of the Palestinian people.

See the recent PHM Statement against the targeting of health workers in Palestine by Israeli occupation forces; including:

> *The People's Health movement reiterates its call for international community and humanitarian organisations to intervene immediately in order to put pressure on the Israeli government to lift the ongoing blockade of the Gaza Strip which threatens a humanitarian and health disaster. The Gaza Strip continues to witness a deterioration in living standards, increased unemployment and reliance on economic aid as well is a severe shortage of medical supplies, medicines, and sanitation, as well as treatment and rehabilitation services.*

15.1 Overview of financial situation: Programme budget 2018–2019

In focus

The Secretariat report (A72/34) describes the current status of financing and implementation of the Programme budget 2018–2019.

It appears that in aggregate terms the PB18-19 will be fully funded, or close to, assuming that 'projected funding' is realised. However, two thirds of revenue will be tightly earmarked and it is clear that donor priorities do not match the prioritization of Member States in Assembly. NCDs and Emergencies are and will remain underfunded, relative to approved budget.

The report refers to a new "resource mobilization and partnership strategy" targeting different donor categories.

The report mentions but does not report on the first Partners' Forum in early April.

Background

Tracker links to previous discussions of PB18-19

PHM Comment

The donor chokehold over WHO's workplan remains in place.

The DG has chosen not to revisit (at least for now) Dr Chan's demands for increases in assessed contributions.

Instead he is wooing emerging member states and private sector donors. It maybe that being seen to be private sector friendly is insurance against significant cuts in US funding.

The DG needs to be pressed to demonstrate that his new "resource mobilization strategic framework" is working.

15.2 WHO programmatic and financial report for 2018–2019, including audited financial statements for 2018

In focus

- A72/35 - WHO Results Report, PB18-19, Mid-Term Review
- A72/36 - Audited financial statements for the year ended 31 December 2018
- A72/INF./5 - Voluntary contributions by fund and by contributor, 2018
- WHO program budget portal

Background

- Tracker links to previous financial reports, including PHM commentaries

PHM Comment

Results report mid-term review of PB18-19

Under the health services category, in the body of the report, UHC is again identified with safety net health insurance and mixed/private healthcare delivery in the celebration of Ayushman Bharat in India and the WHO recommended "modest health benefit package" in Kenya. The discussion of access to medicines is largely restricted to prequalification with no reference to TRIPS flexibilities. The reference to pricing transparency is appreciated. Likewise the commitment to full transparency of clinical trials.

Noteworthy, in the financial data for the health systems category, is, first, that 70% of funds available take the form of highly specified voluntary contributions; and second, that funds mobilisation and expenditure levels remain a concern in the region of the Americas and in the eastern Mediterranean region.

The results reported under the WHO health emergencies program are impressive. WHO's performance in relation to Ebola has been excellent although the deteriorating situation in Kivu province is very concerning. It is frustrating to read about cholera in Yemen and diphtheria among Rohingya refugees and the conflict context of Ebola in the DRC all of which reflect egregious failures in global security and sustainable development.

Noteworthy, in the financial data regarding emergencies, are first the dependence on specified voluntary contributions (71%); second the shortfall in funds mobilisation for all of the sub- programs under emergencies and the low expenditure rates in the sub- programs.Under the humanitarian appeals component, the largest expenditure is on essential health and nutrition services but there appear to have been obstacles to rapid deployment of the funding available.

The results reported under the life course category are to be appreciated, including work on maternal mortality, under fives mortality, STIs, aging, air pollution and climate. Noteworthy in the financial data regarding this category are: first, the continuing dependence on specified voluntary contributions (68%); second, the under funding of the reproductive, maternal and child health program, health and the environment and equity social determinants; and the underspending in all of the programs and in all of the regions. The report explains that the under expenditure is a consequence of insecure and inadequate funding from the donors which impacts on staffing levels and hence on expenditure capacity. The exception

is the special program of research, development and research training in human reproduction which is funded above the approved budget (but also appears to have under spent).

Under the noncommunicable diseases category some excellent instances of WHO actions are cited. However, this category, the smallest in budget estimate terms, is underfunded and under spent in all regions including headquarters and across all programs. The lack of support from donors is reflected in the relatively high dependence on flexible funding (42%) with specified voluntary contributions down to 58%.

Under the communicable diseases category specified voluntary contributions constitutes 87% of total funding. In most of the the programs which make up this category funds mobilisation is well below budget and expenditure correspondingly low. The exception is vaccine preventable diseases which has been oversubscribed relative to budget and for which expenditure is on track. Funding for the different offices of WHO is generally at or close to budget with the exception of Africa for which funds mobilisation is well below budget and accordingly expenditure well below budget. The narrative explains that the apparent over funding of vaccine preventable diseases reflects a budget adjustment made during the course of the biennium to accommodate the pilot malaria vaccine implementation program.

The global polio eradication initiative is inching towards eradication, overcoming significant barriers and at significant cost. The GPEI is funded 100% from voluntary contributions specified with the Gates foundation contributing 27% of this cost. Funds mobilisation remains significantly lower than budget. In terms of funding the different offices, the salient features include headquarters being seriously under subscribed, Eastern Mediterranean being oversubscribed and Africa tracking to match budget with funding.

The final category, leadership and enabling functions, is largely funded through assessed contributions (flexible funding 94%; specified VC 6%). All of the program areas are undersubscribed and under spent accordingly. The budget for headquarters in this category is seriously underfunded.

Among the donors, the top three are USA, Gates, UK. Germany, UK, Sweden Australia and Norway give a significant proportion of their voluntary contributions as untied or flexible. US and Gates funding is all highly specified.

Member states provide 51% of total revenue followed by UN/intergovernmental/development banks at 16%, followed by philanthropic foundations at 13%, followed by partnerships and non-government organisations on 9% and private sector entities at 2% (includes in-kind).

Audited financial statements for year ended 31 December 2018

Largely technical accounting detail.

The DG's list of significant risks to the organisation from page 6 is worth reviewing.

General comment

The donor chokehold over WHO’s workplan remains in place.

The DG has chosen not to revisit (at least for now) Dr Chan’s demands for modest increases in assessed contributions.

Instead he is wooing two somewhat different categories of donor: ‘emerging member states’ and private sector. It maybe that being seen to be private sector friendly is insurance against significant cuts in US funding. Private sector funding may have been somewhat disappointing at only 2% of total revenue.

Despite repeated calls for the untying of tightly specified voluntary contributions most donor's remain insistent on tight specification.

15.3 Status of collection of assessed contributions, including Member States in arrears in the payment of their contributions to an extent that would justify invoking Article 7 of the Constitution

In focus

See A72/37 including draft resolution regarding Congo, Dominican Republic, Egypt, Nauru, North Macedonia, Paraguay, Senegal, Sudan and Tonga.

15.5 Scale of assessments

In focus

A72/38 and resolution EB144.R6

Background

PHM EB144 commentary

16.1 Report of the External Auditor

In focus

A72/39 (55 page document posted on 9 May!)

Background

Tracker links to previous discussions of reports of the External Auditor. See also A72/41 for the DG report on the implementation of audit recommendations.

PHM Comment

This report covers a number of topics of policy significance, including:

- WHO resource mobilisation and the management of donor awards,
- management of the WHO health emergencies program, and
- the governance of the FCTC.

16.2 Report of the Internal Auditor

In focus

A72/40

Background

Tracker links to previous discussions of reports of the Internal Auditor

Congratulations to the (very few) units or programs that were rated with an unqualified ‘satisfactory’:

- Immunization and Vaccine Development programme at SEARO;
- Payroll at GSC;
- Ukraine country office,
- Mongolia country office

Concern regarding the (only) unit rated unsatisfactory:

- Yemen country office

Systemic concerns:

- direct financial cooperation,
- direct implementation,
- procurement,
- staff allocation,
- resource mobilisation

Implementation of audit recommendations (see Annex 1)

Cases investigated (see Annex 6):

- fraud (esp procurement and health insurance)
- failure to comply with professional standards
- harassment and sexual harassment
- recruitment irregularity

Assessment of WHO's Principal Risks

- Annex 7
- also website

16.3 External and internal audit recommendations: progress on implementation

In focus

A72/41 provides an update of actions taken by the Secretariat to ensure full implementation of the recommendations made in the reports to this Assembly by the External Auditor (in A72/39) and the Internal Auditor (in A72/40).

Background

See Tracker links to previous discussions of audit reports.

PHM Comment

Under development

17.1 Human resources: annual report

In focus

A72/43 provides an overview of the latest developments with regard to WHO's workforce, diversity, performance management, prevention of sexual harassment and the global internship programme.

Background

Tracker links to previous HR Reports

PHM Comment

Commentary under development. See PHM comment at WHA71.

18.1 WHO reform processes, including the transformation agenda, and implementation of United Nations development system reform

In focus

A72/48 - the Transformation Agenda provides an overview of the work to date on WHO Transformation. It canvasses the case for change; promises a priority to country level work; and explains directions in cultural and operational development.

A72/49 includes information on how the transformation agenda is aligned with the reform of the United Nations development system.

A72/50 conveys a draft decision recommended from EB144 (Decision EB144(4)) in concerning gender specific language in WHO's rules of procedure.

A72/51 - conveys a proposed draft decision forwarded from the EB in EB144(3) which deals with a number of procedural reforms in the management of governing body agendas, communications and actions arising out of the EB consideration of EB144/34 which conveyed the outcomes of informal consultations on governance reform (Geneva, 12 and 13 September, and 23 and 24 October 2018) in the form of the Chairperson's summary and proposed way forward.

Decision EB143(7) packages a further set of procedural reforms elaborated in EB143/3 and recommended by the EB in May 2018.

A72/52 - Governance reform presents for adoption a revised set of Rules of Procedures for the Assembly including provisions for electronic voting, electronic processing of credentials, voting privileges in plenary and suspending debate.

A72/INF./4 provides an overview both of WHO's current country presence and of the plans for an enhanced future country presence for the Organization.

Background

See Tracker links to previous discussions of WHO Reform

PHM Comment

PHM comment under development. See PHM comment on this item at EB144 here

18.2 Multilingualism

In focus

A72/53

19 Other matters referred to the Health Assembly by the Executive Board

In focus

- A72/54 Rev.1 - 2020: International Year of Nursing and Midwifery
- A72/55 Rev.1 - World Chagas Disease Day

20 Collaboration within the United Nations system and with other intergovernmental organizations

In focus

- A72/56 (NYP, perhaps cancelled)

21.1 Strengthening synergies between the World Health Assembly and the Conference of the Parties (COP) to the WHO Framework Convention on Tobacco Control (FCTC)

In focus

A72/57 conveys a report of FCTC COP8 from the Head of the Convention Secretariat.

This report is prepared and presented in accordance with WHA69(13) in which the Assembly decided to invite a report from the FCTC for consideration by the Assembly (and agreed to submit a reciprocal report from the Assembly to the COP). See A69/11.

Highlights of the COP8 report include:

- adoption of the Global Strategy to Accelerate Tobacco Control: Advancing Sustainable Development through Implementation of the WHO FCTC 2019–2025;
- measures to protect the integrity of COP deliberations from being undermined by observers who are aligned with the tobacco industry or delegation members who are likewise aligned;
- entry into force of the Protocol to Eliminate Illicit Trade in Tobacco Products;
- action on:
    - cross-border tobacco promotion;
    - novel and emerging tobacco products and electronic nicotine delivery systems;
    - alternative livelihoods.

Background

See also:

- WHO global report 2017;
- WHO global trends (country profiles) report 2015;
- main index page for FCTC;
- main documents page for COP8; and
- decisions page for COP8.

PHM Comment

21.2 Outcome of the Second International Conference on Nutrition

In focus

The report (in A72/58) describes progress in policy development during the 2017–2018 at national and global level in relation to the outcome documents of the Second International Conference on Nutrition (ICN2) (see Rome Declaration and Framework for Action 2015) and the proclamation of the United Nations Decade of Action on Nutrition.

The report also provides an update on the implementation of the 2016 recommendations of the Ending Childhood Obesity Commission (ECHO).

The report reviews a range of further nutrition related initiatives from WHO and other UN agencies and notes MS commitments to implement recommendations included in these.

More detailed data on nutrition policy are provided in the Global Nutrition Policy Review 2016–2017 but only at the regional level. Country specific data are accessible (with difficulty) from GINA.

A72/58 also sets out a number of areas where, in the view of WHO and FAO, intensified action is required.

Background

Tracker links to previous discussions of ICN2 and ECHO.

See also the Public Interest CSOs and Social Movements Vision Statement adopted at the Public Interest CSOs and Social Movements Pre ICN Conference in November 2015 and the Social Movements Statement issued by social movements attending the pre-conference.

PHM Comment

The underlying purpose of this report is to strengthen the accountability of member states for the implementation of commitments made at ICN2 and in a range of more recent international gatherings (summarised in para 14).

Detailed country level data on nutrition policy, programs, mechanisms and actions are provided in the WHO/FAO GINA database although it is not easy to access.

PHM criticisms of the Outcome Documents of ICN2 are worth revisiting (here). PHM was particularly critical of the voluntary nature of all of the commitments but supported the development of national nutrition plans as recommended in the Framework for Action and highlighted the need to build the domestic constituency to drive the implementation of such plans.

The data summarised in A72/58 (and provided in more detail in the Global Nutrition Policy Review and in GINA) provide rich material for social movements and professional organisations to hold to account their governments for implementing the (voluntary) commitments they made in Rome in 2015 and in other subsequent meetings, resolutions and declarations.

PHM was critical of the weaknesses of the Outcome Documents in relation to food systems (in particular, issues of food sovereignty and agroecology); the impact of the prevailing trade regime on food systems; and the lack of effective regulation of transnational food corporations. These remain key issues and largely beyond the scope of the official ICN2 outcome documents.

The Assembly's support for the report of the ECHO Commission was highly qualified. In decision WHA69(12) the Assembly 'welcomed' the report and asked the Secretariat to develop an Implementation Plan. In decision WHA70(19) the Assembly 'welcomed' the Implementation Plan and urged MSs to 'develop

national responses', 'taking into account' the recommendations of the Implementation Plan. Nonetheless there is much useful material in the original report and the implementation plan and governments should be challenged to implement fully.

20.3 Progress reports

In focus

A72/59

Resolutions

- A. Global technical strategy and targets for malaria 2016–2030 (resolution WHA68.2 (2015))
- B. Mycetoma (resolution WHA69.21 (2016))
- C. Eradication of dracunculiasis (resolution WHA64.16 (2011))
- D. Sustaining the elimination of iodine deficiency disorders (resolution WHA60.21 (2007))
- E. Prevention of deafness and hearing loss (resolution WHA70.13 (2017))
- F. Strategy for integrating gender analysis and actions into the work of WHO (resolution WHA60.25 (2007))
- G. The role of the health sector in the Strategic Approach to International Chemicals Management towards the 2020 goal and beyond (decision WHA70(23) (2017))
- H. Regulatory system strengthening for medical products (resolution WHA67.20 (2014))
- I. Progress in the rational use of medicines (resolution WHA60.16 (2007))
- J. Traditional medicine (resolution WHA67.18 (2014))

A. Global technical strategy and targets for malaria 2016–2030 (resolution WHA68.2 (2015))

Progress reported

Progress has stalled. Funding is inadequate. New tools are needed. Use of bednets is static. Rate of indoor spraying very low. Chemoprevention is under-utilised. ACTs are under-accessed.

This report more pessimistic than A70/38 in 2017.

Comment

435,000 deaths in 2017 (mainly in Sub-Saharan Africa) reflect urgency of health system strengthening, based on PHC; economic development (decent housing and living conditions) and a new international economic order. Technical advice will remain of limited effectiveness until these big picture issues are addressed.

B. Mycetoma (resolution WHA69.21 (2016))

Progress reported

Survey of member states summarised. WHO supporting networking of scientists and public health people and seeking to mobilise funds for research. Urgent need for improved diagnostics and medicines.

Comment

Mycetoma illustrates the failure of profit driven research and development. Sudan, where the prevalence is highest faces poverty, conflict, and weak governance.

C. Eradication of dracunculiasis (resolution WHA64.16 (2011))

Progress reported

This is a success story:

In 2018, only three countries reported a total of 28 human cases of dracunculiasis, namely, Angola (one case), Chad (17 cases) and South Sudan (10 cases), from a total of 22 villages; when eradication efforts were launched in the 1980s, the disease was endemic in 20 countries. Ethiopia reported zero human cases, as has Mali since 2016.

It is interesting to return to A64/20 (from 2011) which informed resolution WHA64.16:

- The annual incidence of dracunculiasis has declined remarkably. In 2010 only 1797 new cases were reported, a reduction of 89% compared to the 16 026 reported in 2004, and a reduction of more than 99% compared to the estimated 3.5 million infected people in 1986.
- The number of disease-endemic countries has been reduced from the 12 countries that signed the Geneva Declaration in 2004 to four countries (Ethiopia, Ghana, Mali and Sudan) by the end of 2010, a reduction of 67% and a decrease of 80% compared to the 20 countries that were endemic for the disease during the 1980s.
- The number of villages that reported cases in 2010 was 779, representing a decrease of 79% compared to 3625 villages in 2004 and 97% compared to the peak of 23 735 villages in 1991.

Previous reports

D. Sustaining the elimination of iodine deficiency disorders (resolution WHA60.21 (2007))

Progress reported

The numbers of countries with insufficient iodine intakes continues to fall. Ongoing monitoring is necessary to prevent excessive intakes. Optimal iodine intake among pregnant women slower to achieve.

Mandatory iodine supplementation of salt the key intervention plus supplementation for pregnant women as needed.

WHA60.21 was actually a fairly brief resolution arose out of a report on implementation of an earlier and more substantive resolution WHA58.24 (2005).

See previous reports on Iodine deficiency.

Comment

Another public health success story although governments must be held to account for implementing key policies, including adequate monitoring.

Why are rich countries like Finland, Israel, Italy, Lichtenstein, and Russia among those with insufficient iodine intakes?

E. Prevention of deafness and hearing loss (resolution WHA70.13 (2017))

Progress reported

A70/34 provided an overview of estimated prevalence, distribution, causes and consequences of hearing loss.

WHA70.13 (2017) set out recommended actions for member states and for the Secretariat. Progress report E, before the WHA72, reports on what the Secretariat has done but there is no report on recommended actions taken (or not) by member states.

F. Strategy for integrating gender analysis and actions into the work of WHO (resolution WHA60.25 (2007))

Resolution WHA60.25 endorsed the Strategy. Progress in implementing the strategy has been reported at several assemblies since then (see previous reports).

This report states that implementation of WH60.25 “has become the cornerstone for scaling up WHO action towards, and achieving, the health- and equality-related targets of the Sustainable Development Goals”.

The Strategy quotes the 1995 Beijing Conference as declaring that “gender mainstreaming is a major strategy for the promotion of gender equality”. The Strategy quotes the UN Economic and Social Council as saying that “The ultimate goal of mainstreaming is to achieve gender equality”.

Following the WHA60.25 there has been inclusion of more nuanced language in the context of gender that embraces its diversity and is beyond gender binaries. However, the current as well as previous reports have not sufficiently addressed this whether in terms of programmes, policies or disaggregated data, particularly with reference to queer and transgender populations.

This report on progress in implementing the strategy commences with a two line account of “country progress” about what member states have achieved; this “progress” quotes an extremely weak and inadequate indicator (the number of countries who have implemented (self-report) ‘at least two WHO-supported activities …’) and reports on the increase in the number of countries who have done this. It is unclear whether these activities actually resulted in changes in policy and programmes through gender integration. The latter would be a more substantive indicator and can be corroborated with country level data.

While Secretariat technical support activities (training, analysis, handbook, working group, fact sheets etc) and other activities to integrate gender are important, this is the bulk and most central to the report. However, measurement of implementation # 3.4.2 “A social determinants of health approach to improving health and reducing health inequities integrated in national, regional and global health programmes and strategies, as well as in WHO” which is necessary for strengthening equity and accountability, is absent.

The absence of any significant reporting of member state implementation activities further reduces the value of this report in terms of strengthening the accountability of member states for working towards gender equity. This contrasts sharply with the country data reported in WHO’s own Health Equity Monitor and in the OECD Social Institutions and Gender Index linked from the Secretariat’s gender page.

The timidity of this ‘progress’ report reflects a fundamental limitation of member state governance and the weakness of member state accountability. Countries with patriarchal cultures are likely to have patriarchal governments for whom gender equity and gender integration may be not high priorities.

There is no reference in this report to the regional and category ‘focal points’ referred to in the Roadmap for action, 2014-2019, Integrating equity, gender, human rights and social determinants into the work of WHO (here).

The Roadmap as well as the indicators / reporting milestones have not been updated to align with GPW13 as was originally intended.

The UN SDGs website (here) provides some facts and figures regarding gender equality which point to the huge disease burden associated with gender inequality. The website lists the Goal 5 targets which are high on ambition albeit low on strategy.

There is, however, a stark dysjunction between the magnitude of the disease burden associated with gender inequality and the relatively limited reach of the activities reported in A72/59 F.

The human rights organisations, feminist movements (globally, regionally, nationally) and other feminist informed social movements, like PHM, are working towards gender equity but are presently denied the full support of the WHO Secretariat.

The implementation WHA60.25 and the achievement of the SDG5 goals could be dramatically accelerated through closer collaboration between the Secretariat at all three levels and progressive social movements, in particular, the feminist, transgender and queer, health and other social movements. Progressive member states are urged to consider a new resolution which explicitly mandates such collaborations towards promoting the accountability of member states in integration gender, equity and human rights.

G. The role of the health sector in the Strategic Approach to International Chemicals Management towards the 2020 goal and beyond (decision WHA70(23) (2017))

In focus

A72/59 G reports on:

- the implementation of the 'road map to enhance health sector engagement in the Strategic Approach to International Chemicals Management and beyond' (as approved in WHA70(23) and in accordance with the reporting requested in WHA70(23)), and
- the role of WHO and ministries of public health (report A67/24 and resolution WHA67.11) in the implementation of the Minamata Convention (as requested by Uruguay - which presided over the negotiation of the Convention - at WHA70 (A14)).

Background

The Tracker provides links to the sequence of governing body discussions on both of these issues including reports, debates, decisions and PHM comments. See also WHO's page on the health impacts of chemicals.

PHM's comment on Item 13.6 at WHA69 (2016) provides an historical overview of the development of international cooperation in the management of chemicals in the environment including the development of the Strategic Approach (SAICM).See also the ENB history of SAICM here.

The PHM comment also traces concerns expressed about the lack of engagement by health ministers in the implementation of the Strategic Approach. This was considered at EB138 (Jan 2016) but the Board did not find consensus. It was considered again at WHA69 (May 2016) and the Assembly commissioned the development of a road map 'outlining concrete actions to enhance health sector engagement' in the SAICM. The road map was produced (in A70/36) and adopted (in WHA70(23)).

In A69/19 the Secretariat noted that the SAICM would conclude in 2020 and urged health ministries to participate in the intersessional process initiated at ICCM4 to establish new arrangements for the sound management of chemicals and waste after 2020.

PHM's comment at WHA69 also reviews some of the long-standing debates in the chemicals and waste field over regulatory strategies, structures and capacity building.

PHM's comment on Item 16.2 at WHA70 highlights some of the contentious issues in international chemicals and waste management, highlighting transboundary traffic in toxic waste and debates over asbestos. The comment is critical of the road map for the lack of any mechanisms to ensure member state accountability, the need for action on information and labelling and action in illegal transboundary movement.

The Secretariat's report (in A72/59) on the implementation of WHA70(23) is largely focused on WHO's ongoing contribution to the sound management of chemicals and waste in the environment. There is a brief reference to the discussions in train regarding what will replace the SAICM after 2020.

An important independent evaluation of the SAICM 2006-2015 was commissioned by ICCM4 in 2015 but its final report has been delayed. Meanwhile a very useful draft Executive Summary (dated 1 April 2019) has been provided by the independent evaluator to the 3rd meeting of the Open Ended Working Group of the ICCM (SAICM/OEWG.3/3). The Executive Summary provides a very useful overview of the development of the SAICM and the various structures and processes within which it works (see Fig 2). The Conclusions of the Independent Evaluator (from page 23) are very useful, in particular the summary of weaknesses, gaps and learnings.

Planning and negotiations around the international regulation of chemicals and waste after 2020 has been managed within the Intersessional Process established by ICCM4 in 2015.

ICCM4 agreed that the intersessional process should be open to all stakeholders and include, in principle, two meetings before the third meeting of the SAICM Open-ended Working Group (to be held in 2018 or early 2019) and one meeting between the third meeting of the SAICM Open-ended Working Group and the fifth session of the ICCM (scheduled for 2020).

The OEWG3 was held in Montevideo, Uruguay, from 2-4 April 2019. The OEWG3 website provides links to a raft of useful documents. The OEWG received a report from the co-chairs of the intersessional process regarding the progress that had been achieved through the intersessional process. The co-chairs' report comes in two versions: the Paper by the co-chairs (SAICM/OEWG.3/4) and the Annotations to the Paper (SAICM/OEWG.3/INF/2) by the co-chairs. The annotations are particularly useful.

The IISD report on the outcomes of the OEWG3 (here) provides a very useful summary of the discussions and decisions.

Minamata. A67/24 (2014) provides a brief overview of sources of mercury exposures and health impacts. It recounts the negotiation and adoption of the Minamata Convention on Mercury and reviews the role of health ministries in the implementation of the Convention and the role of WHO in implementing the Convention. To this point 107 countries have ratified the Convention.

See WHO (2018) Health Sector involvement in the Minamata Convention.

Comment

It is apparent that the international management of chemicals and waste is fragmented, underfunded, patchy in its coverage and in many respects ineffective.

Discussions are proceeding under the aegis of the OEWG but health ministries, public health academics and civil society health organisations have not been active.

It is unfortunate that the progress report in A72/59 does not canvas the substantive and structural issues being considered under the OEWG regarding the ongoing international regulation of chemicals and wastes.

H. Regulatory system strengthening for medical products (resolution WHA67.20 (2014))

A67/32 (2014), which informed the adoption of WHA67.20, lists the activities which are included under the regulatory system for medical products:

- licensing the manufacture, import, export, distribution, promotion and advertising of medicines and medical products;
- assessing the safety, efficacy and quality of medical products, and issuing marketing authorization;
- inspecting, and conducting surveillance of, manufacturers, importers, wholesalers and dispensers of medicines and medical products;
- controlling and monitoring the quality of medical products on the market;
- controlling the promotion and advertising of medical products;
- monitoring adverse reactions to medicines and medical products;
- providing independent information on medicines to professionals and the public.

Interestingly it did not include regulating the prescription and use of medicines.

A number of parallel influences contributed to the emergence of this resolution:

- the debates around substandard and falsified medical products, including the process of separating out the IP issues from questions of quality, safety and efficacy:
    - the ambiguous use of the term 'counterfeit';
    - the insertion of patent linkage provisions in trade agreements;
    - the role of extreme IP protection in raising the price of medicines;
    - pharm initiatives designed to persuade governments to legislate to harness the authority of medicines regulatory agencies in policing IP claims;
- the rising importance of financial barriers to access and the need to expand domestic production (which has regulatory implications);
- concern regarding shortages (especially of vaccines) and stockouts;
- the rising importance of biological medicines, cellular therapies in vitro diagnostics and the need to clarify the appropriate regulatory framework for biosimilars;
- the pressures on WHO's prequalification program;
- a rising appreciation of the disease burden associated with harms arising in health care;

- the rising prevalence of antimicrobial resistance.

Resolution WHA67.20 (2014) urges a number of specific activities for member states and for the Secretariat but the core strategy was regulatory system evaluation and benchmarking, development of institutional development plans and technical support.

See also the WHO webpages for medicines regulation and regulatory strengthening.

A72/59 H reports progress including:

- the unified global benchmarking tool,
- continued work on norms and standards,
- guidance documents, workshops, missions etc,
- strengthening the prequalification program,
- support for regional regulatory networks,
- coordination with the Member State Mechanism on Substandard and Falsified MPs,

This report is very similar to the report provided to WHA70 (2017) in A70/38 J.

It is very hard to get a sense of where we stand globally with respect to regulatory capacity from this report. A very useful report from 2010, 'Assessment of medicines regulatory systems in sub-Saharan Africa' (here) was prepared by analysing the findings of 26 assessment reports. This exercise does not seem to have been repeated since nor are there comparable reports for other regions.

The output indicators for Output 4.3.3 which includes regulatory strengthening (in PB18-19 A70/7) quotes as one of the output indicators, the 'number of national regulatory authorities ensuring core regulatory functions for medicines and vaccines'. The baseline figure for this was 50/194 (in 2015). The target for this indicator was 72/194 for 2019 but there is no reference to this indicator in this progress report.

In the absence of any information on real progress in regulatory system strengthening (rather than reports of Secretariat activities) it is hard to make a judgement about progress.

As this is the last prescribed progress report for this resolution it would be appropriate to give some consideration to next steps.

Resolution WHA67.20 (2014) explicitly excluded duplicating or circumventing the work plan and mandate of the Member State Mechanism. A great deal of work, essentially about regulatory strengthening, is being driven through the MSM. Presumably at some stage this will be folded into the relevant programme of the Secretariat.

I. Progress in the rational use of medicines (resolution WHA60.16 (2007))

The 'progress report' in A72/59 ignores most of the provisions of WHA60.16. The table below lists the main provisions pertaining to MSs and to the Secretariat and notes the presence of any substantive reporting information.

Urges Member States	Requests the DG	A72/59
Institutional strengthening for RUM		
National agency or regulatory agency to monitor and promote RUM	Support countries in implementing such agencies	Surveillance of antibiotic use
Apply the EML to health insurance benefit packages		
Professional and public education re RUM		Action in the Euro region

Monitor promotion; ban inaccurate, misleading or unethical promotion		
Implement independent unbiased non-commercial information provision		
Establish and promote EMLs and clinical guidelines		
Strengthen the role of hospital D&TCs		
	Strengthen leadership and advocacy re RUM, including promote relevant research	Progress with EML Advocating antimicrobial stewardship
	Mobilise funds to support RUM	SEARO

It seems that with a few specific exceptions most of the activities committed to in WHA60.16 are in abeyance. Most of the report deals with initiatives implemented because of the threat of antimicrobial resistance.

These are important but they leave the wider problem of inappropriate use untouched.

PHM urges member states to recommit to effective action towards the rational use of medicines including in particular:

- Institutional strengthening for RUM
- Create national agency or regulatory agency to monitor and promote RUM
- Support professional and public education re RUM
- Monitor promotion; ban inaccurate, misleading or unethical promotion
- Implement independent unbiased non-commercial information provision
- Establish and promote EMLs and clinical guidelines
- Strengthen the role of hospital D&TCs

See previous progress reports here.

J. Traditional medicine (resolution WHA67.18 (2014))

The main point of WHA67.18 was to implement the WHO Traditional Medicines Strategy. The resolution urged MSs to adapt, adopt and implement the Strategy and asked the Secretariat to support this movement, including ensuring adequate funding.

The report in A72/59 provides some broad brush indicators of member state progress (slow) and lists a range of activities being undertaken through the Secretariat (guidelines, terminologies, tools, etc).