

People's Health Movement

Background and Commentary on Items before EB150 January 2022 (Final Version)

This analysis and commentary on items coming before the WHO Executive Board in Jan 2022 has been prepared by the [People's Health Movement](#) as part of WHO Watch, a civil society initiative directed to the democratisation of global health governance ([more about WHO Watch](#)).

This Commentary is produced through PHM's team of policy analysts in consultation with a global network of consultants. The commentary is designed to be read in conjunction with the Secretariat's documents; it does not duplicate the material covered in the official documents.

This PDF version of the PHM Analysis and Commentary is taken from [PHM's Tracker for EB150](#).

This version is the final edition (published 22 Jan 2022) of PHM's commentary. Updates will be published on the Tracker.

Comment and feedback are welcome. Write to editor@phmovement.org.

For ongoing access to WHO Watch alerts and commentary, subscribe to WHO Watch Newsletter (subscribe [here](#)).

Contents

3. Outcome of Second Special Session of World Health Assembly (SSA2)	3
7. Political declaration of 3rd HLM of UNGA on NCDs.....	9
8 Global health sector strategies on HIV, viral hepatitis, & STIs.....	28
9. Global strategy: TB research and innovation	33
10. Roadmap for NTDs 2021-2030.....	36
11. Immunisation agenda 2030.....	39
12. Infection Prevention and Control.....	42
13 Global road map on defeating meningitis by 2030	44
14. Standardisation of medical devices nomenclature	47
15.1 Strengthening WHO preparedness for and response to health emergencies	49
15.2 Standing Committee on Pandemic and Emergency Preparedness and Response.....	51
15.3 WHO's work in health emergencies.....	52
15.4 Influenza preparedness.....	54
15.5 Global Health for Peace Initiative.....	57
16.1 Poliomyelitis eradication.....	61
16.2 Polio transition planning and polio post-certification	65
17. Maternal, infant and young child nutrition	68

18. WHO's implementation framework for Billion 3 and Global Strategy for Food Safety.....	71
19.3 Sustainable financing: report of the Working Group.....	74
21.1 Strategies and plans scheduled to expire: the Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property.....	76
21.2 WHO reform: involvement of non-State actors in WHO's governing bodies	84
21.3 Engagement with non-State actors.....	86
24 Report on meetings of expert committees and study groups: food contaminants, food additives and essential medicines	87

3. Outcome of Second Special Session of World Health Assembly (SSA2)

In focus

Global preparedness and response to the Covid pandemic has included successes, failures and controversies which have raised questions about strengthening global preparedness and in particular WHO's role and capacity for preparedness and response.

The successes, failures and controversies in global preparedness and response have been explored in reports from:

- the [Independent Panel](#) for Pandemic Preparedness and Response (IPPPR),
- the Independent Oversight and Advisory Committee for the WHO Health Emergencies Programme ([A74/16](#)),
- the Review Committee on the Functioning of the International Health Regulations (2005) during the COVID-19 Response ([A74/9 Add.1](#)) and
- the [2019](#), [2020](#) and [2021](#) reports of the Global Preparedness and Monitoring Board.

In Resolution [WHA74.7](#), WHA74 established a Member States Working Group on Strengthening WHO Preparedness and Response to Health Emergencies ([WGPR](#)) to review the recommendations of the above inquiries and to submit a report with proposed actions for the WHO Secretariat, Member States, and non-State actors, for consideration by EB150 and then WHA75;

- the WGPR has published an interim report under this mandate, [A/WGPR/6/3](#), which will be considered by EB150; its final report to be submitted directly to WHA75 will be finalised in early May 2022; (note that this report is listed for discussion under Item 15.1);
- the WGPR has categorised the 131 recommendations from the various panels under five headings (see para 15 of [A/WGPR/6/3](#)) and has invited EB150 to provide advice under these headings:
 - leadership and governance,
 - IHR strengthening,
 - equity in pandemic prevention and response,
 - strengthened health systems, and
 - financing);
- the WGPR has launched a survey of member states and “other stakeholders of the WGPR” ([A/WGPR/1/6](#)) see regarding the recommendations from the various panels which will inform the finalisation of its final report to WHA75 in early May. WGPR expects to review the findings of the survey at its meeting in Feb 2022;
- note that the WG was supposed to submit its final report to EB150 for consideration under Item 15.1; presumably the Board will consider the interim report (in [A/WGPR/6/3](#)) under that item.

in [WHA74\(16\)](#), the Assembly decided to ask the WGPR to prioritise an assessment of the benefits of developing a WHO legal instrument on pandemic preparedness and response and to provide a report for a special session of the Health Assembly (SSA2) to be held in late November, 2021;

- the WGPR published its report to SSA2 in [SSA2/3](#) which was endorsed by SSA2 (1 Dec 2021) in decision [SSA2\(5\)](#), The World Together.
- this decision commits to the creation of an international negotiating body (INB) to commence work no later than 1 March 2022 and to provide a progress report to WHA76 (2023) and final report to WHA77 (2024).

It is not yet clear how much substantive discussion of decision [SSA2\(5\)](#) ('The World Together') there will be under this item. There may be some procedural issues associated with the launching of the INB.

However, the Board may choose to discuss the recommendations of the various panels, presumably under the five headings listed in para 15 of [A/WGPR/6/3](#).

See also [WHO's Dashboard of Covid-19 related Recommendations](#).

PHM Comment

The Annex to [A/WGPR/6/3](#) presents a useful list of the different mechanisms through which the various recommendations from the various inquiries and panels, might be implemented. These are referred to MS categories in the [Dashboard](#).

Regardless of their strategic merit, 88 of the 131 recommendations reviewed by the WG fall into the MS Categories 1 or 2 on the [Dashboard](#): they could be addressed through "existing tools and mechanisms available to WHO (e.g., recommendations that can be implemented through the regular technical work of WHO as per its normative functions, through existing frameworks (International Health Regulations (2005) obligations, and World Health Assembly resolutions/decisions))".

A further 12 are recommendations that "may address or involve external bodies/actors" (Category 5 on the Dashboard) and would not be advanced by WHO adopting a new legal instrument. Several of these are directed at the WB and IMF, variously urging more funding to support pandemic preparedness and response as well as suggesting these institutions use their financial leverage to 'create incentives' for better preparedness. A similar recommendation urges the G7 to properly fund the ACT-Accelerator initiative.

38 recommendations fall into Category 3, could be implemented by amending or building on existing frameworks (the IHRs) or WHA resolutions. Most of these are classified as addressing issues of leadership and governance, in particular IHR implementation and compliance. Many of the IHR Review Committee recommendations and those of the IOAC (see Dashboard) are reasonable and warrant consideration.

51 recommendations are classified on the Dashboard as “recommendations that may effectively/optimally be implemented through new WHO international agreement(s)/instrument(s)”. Several of these deal with research and development: increased funding, better coordination, separation of the funding of global health security from development assistance,

Open licensing to be triggered by pandemic declaration

A key objective should be prompt, equitable and affordable access to medical products, from PPE and vaccines, to tests and treatments.

There have been a range of barriers to such access in the context of Covid;, foremost amongst them has been the use of intellectual property ownership to restrict supply, support prices and yield maximum profits.

A critical provision in the proposed new instrument should be a mechanism to create a link between the declaration of a PHEIC and the triggering of a mandatory open licensing regime, through a mechanism such as C-TAP. This would be mandated through agreed conditions to be imposed by granting agencies and to be included in advanced purchase agreements.

The IPPPR_32 (on the Dashboard) recommends that the WTO and WHO convene major vaccine-producing countries and manufacturers to get agreement on voluntary licensing and technology transfer arrangements for COVID-19 vaccines (including through the Medicines Patent Pool). If actions do not occur within three months, a waiver of intellectual property rights under the Agreement on Trade-Related Aspects of Intellectual Property Rights should come into force immediately.

This is commendable but it is not just about pharma. The TRIPS regime of extreme IP is critical for the neoliberal project with its global value chains focusing on technology at the imperial centre and low wage assembly at the periphery.

Where public health priorities require it, restrictive conditions under bilateral or plurilateral investment protection treaties that in any way limit adequate response by a Member State to the pandemic should be waived and such waivers would not be subject to the arbitration mechanisms under the treaty. This could relate to innovation and manufacture of technologies, and it could also relate to the delivery of essential services by the public sector or under public administration. Such protections may also be required for non-state actors in LMICs. Member States would be obliged to ensure that bilateral investment protection and trade agreements are in compliance with this obligation.

Rapid scale up of research, development and production

It is clear from the Covid experience that the rapid scale up of research and development and production for tests, medicines and vaccines must be a critical element of pandemic preparedness and response.

IPPPR recommendations 20 & 21 on the Dashboard deal with technology transfer, voluntary licensing, and strong financing and regional capacity building for manufacturing, regulation and procurement. Exactly how a new instrument might usefully address these objectives would require further discussion

Strengthening WHO

Clearly financing is WHO's fundamental weakness at this time, owing largely to the freeze of assessed contributions, the insistence by the donors on tightly tying their voluntary contributions and the progressive marginalisation of WHO in GHG; replaced by multistakeholder partnerships like the ACT-A.

Recommendation GPMB_18 on the Dashboard urges that: "Heads of government renew their commitment to the multilateral system and strengthen WHO as an impartial and independent international organization, responsible for directing and coordinating pandemic preparedness & response."

Several of the IPPPR recommendations fall under this heading: 'strengthen the authority of the DG by giving her/him a single 7 year term of office'; 'the DG to be given authority by the WHA to publish information about outbreaks on an immediate basis without national approval', 'establish WHO's financial independence based on fully unearmarked resources'.

The strengthening of WHO including adequate funding is not going to be advanced by a new legal instrument. Rather it calls for increased pressure on member states to increase their assessed contributions and to reverse the transfer of global health functions out of WHO and into new multistakeholder partnerships.

The accountability of national governments

WHO's inability to hold nation states accountable for pandemic planning, implementation and outcomes is a major weakness. After all the finger pointing at LICs for not implementing the IHR core capacities, when the pandemic came the 'capacities' which made a difference included effective and decisive whole-of-government responses, female leadership, transparency, effective public communication by the highest level of government and accountability of decision-makers ([Tangcharoensathien, Singh & Mills 2021](#)). Political leaders whose venality and incompetence contributed to thousands of preventable deaths should be held accountable.

Recommendation GPMB_14 on the Dashboard calls for increased accountability of governments to their citizens.

'After action reviews' conducted in public, led by independent experts, and organized at the regional level would be valuable learning opportunities as well as holding governments to account for their preparedness, transparency, solidarity and response (see [Dalton, CB, Kirk, MD & Durrheim, DN 2022](#), 'Using after-action reviews of outbreaks to enhance public health responses: lessons for COVID-19', Med J Aust, vol. 216, no. 1, pp. 4-9).

The ecological and commercial drivers of pandemic infection

Bold new strategies are called for to reverse the ecological and commercial drivers of pandemic infection including the patterns and scale of innovation, investment and development; extractivism, deforestation, and large scale single product agriculture.

Part of this would be strengthening the One Health approach as a framework for collaboration between plant, animal and human health. However beyond One Health is the environment sector and the financial and economic decision makers who need to be made accountable.

See recommendation IHR_13 on the Dashboard which calls for a One Health approach to preparedness, alert, response and research to emerging zoonotic diseases.

Core capacities

Several of the recommendations listed on the Dashboard suggest a return to the practice of harassing least developed countries who have not put in place the core capacities specified in the IHRs (see IHR_04, IPPPR_12, WHA74_43 on the Dashboard). Insisting on state of the art laboratories, surveillance systems, port of entry controls, etc when local communities do not have access to basic primary health care, including routine immunisation, involves organisational dysjunctions as well as a distortion of basic health priorities.

The capacities which failed most strikingly in the Covid pandemic were core political functions such as:

- building policy coherence across sectors and levels of government,
- managing the tensions between public health imperatives and continuing commercial activities,
- building trust between political and health leaderships and different sectors of the population, in particular, regarding the fluidity of public health evidence and advice during the pandemic;
- (in the rich world) promoting understanding of the need for global solidarity in access to health products

These capacities were completely absent from the Global Health Security Index which determined that the US and the UK were best prepared for a pandemic and they are not specified in the IHRs.

Recommendation GPMB_11 (on the Dashboard) calls for national leaders to take early decisive action based on science, evidence and best practice when confronted with health emergencies.

They should discourage the politicisation of measures to protect public health, ensure social protection, and promote national unity and global solidarity'. Giving teeth to this recommendation would involve strengthening domestic and international accountability.

The definition of core capacity must include having primary health care which should mean a district health systems with adequate system density of facilities and healthcare providers, including frontline health workers and referral systems providing a comprehensive package of essential health care services- and the ability to be able to continue these services without disruption during a crisis.

Good surveillance systems with laboratory support are also essential, but for the least developed countries, the gap between where they are currently and where they need to be should be closed by suitable financing and technical support , organized under WHO leadership.

Sharing of data, samples, technology and benefits

Several recommendations touch upon the sharing of data, samples, technology and benefits in the context of pandemic preparedness and response.

GPMB_05 on the Dashboard urges such sharing but does not mention the reciprocal sharing of of the benefits which follow.

Member states have been debating for several years the principles of access and benefit sharing and how public health can be aligned with the principles of the Nagoya Protocol of the Convention on Biological Diversity. It is not clear how an 'instrument' would add value to this debate.

Supporting the strengthening of strong, resilient and inclusive health systems

The WGPR (see para 15 of [A/WGPR/6/3](#)) has highlighted the importance of health system strengthening as a core dimension of pandemic preparedness.

The synergies which can be achieved in preparedness, surveillance and response from a strong PHC sector with good links to more specialised public health units this should be a leading principle, particularly in view of the collapse of health systems under the weight of Covid in many countries.

However, while there are several recommendations listed on the Dashboard which deal with specific aspects related to pandemic preparedness and response, there are few if any which address the goal of broad health system strengthening.

7. Political declaration of 3rd HLM of UNGA on NCDs

In focus

[EB150/7](#) has been prepared in response to a number of decisions and recommendation summarised in Tables 1 & 2 of EB150/7. (These include decisions [WHA72\(11\)](#) (2019), [EB146\(14\)](#) (2020), [EB148\(3\)](#) (2021), [WHA74\(10\)](#) (2021) and [WHA74\(11\)](#) (2021), as well as resolutions [WHA73.10](#) (2020), [WHA74.4](#) (2021) and [WHA74.5](#) (2021)).

In sum the Director-General was requested to develop eight specific assignments on the prevention and control of noncommunicable diseases and the promotion of mental health, and to submit two progress reports.

The consolidated report is submitted with 10 Annexes pursuant to decision [WHA72\(11\)](#) with its request for consolidated reporting on prevention and control of noncommunicable diseases and the promotion of mental health.

1. [GAP 2013-2030](#)
2. [Diabetes](#)
3. [Oral health](#)
4. [Health systems](#)
5. [Cervical cancer](#)
6. [Mental health](#)
7. [Epilepsy](#)
8. [Alcohol](#)
9. [Obesity](#)
10. [GCM](#)

The Board is invited to note Annexes 5 (elimination of cervical cancer) and 6 (prevention and control of noncommunicable diseases and promotion of mental health) and to consider adopting the draft decision in para 7 of EB150/7 recommending the submission, to WHA75, of the draft policy instruments contained in Annexes:

- 1, the draft implementation roadmap 2023–2030 for the global action plan for the prevention and control of noncommunicable diseases 2013–203;
- 2, the draft recommendations to strengthen diabetes responses;
- 3, the draft global strategy on oral health;
- 4, the draft recommendations on policies for the prevention and control of noncommunicable diseases in humanitarian emergencies;
- 7, the draft intersectoral global action plan on epilepsy and other neurological disorders;
- 8, the draft action plan for implementing the global strategy to reduce the harmful use of alcohol (full action plan in [EB150/7 Add.1](#));
- 9, the draft recommendations for the prevention of obesity; and

- 10, the draft workplan for the global coordination mechanism on the prevention and control of noncommunicable diseases.

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

PHM Comment

This agenda item is a follow up to the Political Declaration Adopted at the Third High Level Meeting of the United Nations General Assembly, held in 2018, in New York on the Prevention and Control of Non-Communicable Diseases. In implementation of this Declaration, the World Health Assembly 74, held in 2021 adopted a set of declarations related to the next steps of WHO in this area. Most of these consisted of developing and presenting a strategy or action plan or implementation road map for adoption by Member States in the next World Health Assembly, in 2022. There are 10 such drafts, each in a separate annexure.

Two of these are follow up progress reports from earlier Assembly recommendations.

These 10 annexes are as follows:

1. [GAP 2013-2030](#): Implementation Road-Map-2023 to 2030; for endorsement
2. [Diabetes](#): Action Plan
3. [Oral health](#): Draft Strategy
4. [Health systems](#): NCDs in Humanitarian Emergencies: Strategy
5. [Cervical cancer](#) Implementation of Strategy: Progress report for noting
6. [NCDs including mental health](#) Progress Report for noting
7. [Epilepsy](#) and Neurological Disorders: Strategy
8. [Alcohol](#): Draft Action Plan
9. [Obesity](#): Strategy
10. [GCM](#): Draft Work Plan

1. Draft Implementation Road Map, 2023-2030, for the Global Action Plan (GAP) for the Prevention and Control of NCDs, 2013-2030

Doc [EB150/7 Annex 1](#)

Doc [A74/10 Add.1](#) - Mid-point evaluation of the implementation of the WHO global action plan for the prevention and control of noncommunicable diseases 2013–2020 (Executive Summary)

Decision [WHA74\(10\)](#) - Follow-up of the political declaration of the third high-level meeting of the General Assembly on the prevention and control of non-communicable diseases

The Board is invited to endorse the draft implementation road map. The road map needs to be significantly strengthened before it is endorsed.

Critical pre-reading for this draft road map is the Mid-point evaluation of the implementation of the global action plan for the prevention and control of NCDs 2013–2020, a summary of which was presented to WHA74 in [A74/10 Add.1](#).

The data presented in the Mid-point evaluation showed that the Global Action Plan is failing. See Tables 1, 2 & 3 in A74/10 Add.1. There has been some progress in tobacco control but much less in other areas. The GAP is failing more seriously in the lower income countries. See Figs 1 & 4. The conclusions of the Mid-point evaluation, in particular the cross-cutting conclusions - C7 to C12 - are of particular concern.

Broadly the Implementation Road Map is calling for three steps:

- a) the clearer identification of the risk factors in the national level and the barriers to implementing known cost effective interventions that address them;
- b) promote intersectoral and multistakeholder collaboration, and
- c) prioritisation of the implementation of most cost-effective and feasible strategies.

While the call for more epidemiological research and studies towards risk factors identification is welcome, it is not knowledge that is the bottleneck to effectively prevent NCDs in LMICs, rather it is the whole nature of the economic development path chosen by, as well as imposed upon, LMICs that is the root cause. This is recognised implicitly in the call to prioritise research ... [into] “economic and commercial determinants and multilevel and multisectoral governance”. However, it is so cautiously expressed as to be almost invisible.

In parallel discussions of communicable disease, the pathogens and vectors are studied closely. However, there needs to be a clear and strong call for root cause analyses to identify the political forces and dynamics which shape the patterns of production and consumption and are driving the NCD epidemic and opposition to effective prevention.

Looming behind the political/commercial drivers is the imposition of unhealthy development models associated with very unequal terms of trade and the arm-twisting by global financial and trade institutions that forces countries to adhere to these models. Thus progress on sustainable development goals 7 to 10 (affordable and clean energy; decent work and economic growth; industry, innovation and infrastructure: reduced inequality) are vital in lowering NCDs. For reducing incidence of new NCDs, it is key to engage not only with the social determinants of health but also with the commercial determinants of malnutrition and ill health; risk factors need to be understood as arising from the nature of commercial globalization and corporate control over systems of production and marketing and ultimately consumption

The call for inter-sectorality (although not a panacea) is welcome and so is the call to engage with those living with NCDs. The need to engage with public interest civil society organizations however needs much greater emphasis and not to be linked to patient groups only. (See C8 of the Mid-point evaluation.) What PHM sees as a problem though is the uncritical inclusion of

private entities, especially those involved in technologies and those with a corporate character, in the critical planning and decision making for NCD control. The requirements for corporate profits are often at great variance from the policies required to reduce risk factors or build appropriate healthcare responses, and the draft does not point to these conflicts of interests. PHMs emphasizes that multistakeholderism ought not (a) include those with easy to prove conflicts of interest in terms of them showing huge monetary commercial gains that benefits them - which would mean no corporate agencies are to be on decision making boards and (b) the 'multistakeholder model should not undermine the responsibility and accountability of governments to their peoples, and further not interfere in the decision-making of intergovernmental bodies.

The priorities for implementation mention primary health care, but without clearly emphasising what exactly it entails. It then includes the prevention and control of NCDs in UHC benefit packages, showing a flawed and limited understanding of what UHC ought to be. Marketised health care where the state or insurance agencies purchase commodified health care services is not a workable solution in most LMICs.

The call for increased funding is appropriate, but without a parallel call for an increase in public health workforce, including better terms of employment for them, it will not lead to meaningful change, or even a sustained increase in financing. Governments in almost all Member States have been reluctant to increase the public health workforce to meet the challenge and NCD control falls through the cracks.

The proposed road map appears to have completely ignored [Rec R7 of the Mid-point evaluation](#): "WHO Secretariat to undertake a functional review to consider the extent to which its structure and capacity are optimal for providing technical support to NCD responses".

2. Draft recommendations to strengthen and monitor diabetes responses within national noncommunicable disease programmes, including potential targets

Doc [EB150/7 Annex 2](#)

Doc [Annex 11 of A74/10 Rev.1](#) - Major obstacles to achieving the diabetes-related targets in the who global action plan on the prevention and control of NCDs (2013–2030)

Resolution [WHA74.4](#) - Reducing the burden of noncommunicable diseases through strengthening prevention and control of diabetes

[WHO dialogue with private sector on medicines and technologies for diabetes care](#), September 2021

Annex 2 presents a set of draft recommendations to strengthen and monitor diabetes responses within national NCD programmes, including potential targets. The proposed targets are reasonable but the recommendations need to be strengthened.

Annex 2 documents the rising prevalence of diabetes, with increasing risk factors, in particular an increase in obesity and in physical inactivity. Tobacco is the other major risk factor. Nothing is mentioned about the role of Big Food in food consumption patterns leading to obesity. The draft also informs us that access to diabetes care within a primary healthcare setting and access to the essential medication to prevent complications in diabetes, remains a challenge in most Member States. In most LMICs the supplies required for diagnosis and primary care management of diabetes are unavailable within the selective package of healthcare services that public primary health care providers are restricted to by policy.

100 years after its discovery, “Insulin and associated health technology products remain unaffordable in many countries, particularly for patients paying out-of-pocket or for health systems in many low- and middle-income countries that are unable to provide sustained and equitable coverage for all people with diabetes due to the high prices of these products”.

The draft recommends that five global diabetes coverage targets be established for achievement by 2030:

1. 80% of people with diabetes are diagnosed;
2. 80% of people with diagnosed diabetes have good control of glycaemia
3. 80% of people with diagnosed diabetes have good control of blood pressure;
4. 60% of people with diabetes of 40 years or older receive statins; and
5. 100% of people with type 1 diabetes have access to affordable insulin treatment and blood glucose self-monitoring

The recommendations are pitched towards countries, international partners and WHO.

The recommendations for national level action call for action against “modifiable risk factors” and for better monitoring and for more research. They also call for the integration of diabetes care into people-centred PHC and UHC. This is critical. However, if UHC is taken to mean a minimal safety net defined in terms of specific services to be purchased in a marketised system the outlook for improved diabetes care is bleak.

The Annex assigns to WHO responsibility for addressing the challenge of access to insulin and related technologies but appears wedded to a very cautious strategy which boils down to asking pharma and the other technology companies to be nice. WHO’s [‘biannual private sector dialogues’](#) with representatives from international business associations, and the pharmaceutical and health technology industry are directed to *‘mobilizing commitments and contributions by the private sector toward the noncommunicable diseases response’*. In the first instance WHO is asking the corporations to support ‘quantification, pooled procurement and cold chain integration of insulin’.

Under the new Global Diabetes Compact, *“WHO is now asking for commitments from the pharmaceutical, health technology product, and related private sector industries as part of the Compact. So far, we have identified 31 meaningful and effective commitments that these industries could support. These include guaranteeing uninterrupted supplies of human insulin*

for lower-income countries, participating in future insulin procurement mechanisms, and engaging in WHO's prequalification programme for insulin and associated technologies” ([Hunt et al 2021](#)).

This supplicant strategy is inappropriate, inadequate, and doomed to fail.

Policies around access to essential technologies must learn from the failures witnessed in the Covid pandemic with deliberate supply restrictions, and tight restrictions on access to intellectual property, imposed in order to boost profits. PHM calls for a root and branch reform of all aspects of the current regime encompassing drug innovation, intellectual property, manufacture, trade, procurement, distribution, prescription practices and rational use.

It is evident that diabetes is a Type II disease, in accordance with the CMH taxonomy ([CPHIIPRs 2006](#)); such diseases “are incident in both rich and poor countries, but with a substantial proportion of the cases in the poor countries” and the gap between needs and delivery is most acute in LMICs. Accordingly WHO should be promoting a much wider range of strategies including the full use of TRIPS flexibilities and support for scaling up of public sector production in the global South.

With respect to commercial determinants, addressing the aggressive commercialization of ultra-processed foods needs to be prioritized by this as well as most other NCD programs, and WHO must initiate processes of binding regulation pertaining to the same.

Finally it is important to guard against diabetes control becoming a stand-alone policy. The introduction of this program must go along with the introduction of programs against hypertension, cardiovascular disease, chronic obstructive pulmonary disease at the very least, and must seek synergies with the programs for mental health and other NCDs.

3. Draft global strategy on oral health

Doc [EB150/7 Annex 3](#)

Resolution [WHA74.5 - Oral health](#)

The Board is invited to endorse the draft strategy outlined in Annex 3.

The annex describes the global prevalence and distribution of oral ill-health including the social, economic and environmental costs (mercury). It refers to the social and commercial determinants of poor oral health and summarises the principles of oral health promotion and disease prevention. It describes the elements of oral health care and systems.

The goal of the strategy is to guide Member States in promoting oral health, reducing oral diseases and oral health inequalities and to strengthen oral health care. The draft strategy is based on six guiding principles, including people-centred care, a base in primary health care, and inclusion in UHC. Drawing on these six principles are six strategic objectives which are reasonably comprehensive.

Finally the draft sets out the proposed roles of WHO, member states and 'partners'. These are all quite sensible. Four issues call for particular attention.

Oral health care systems. Integrating oral health care into an organised and publicly funded primary health care system is a high priority, particularly in countries where dental care is largely based in the private sector, largely unaccountable and highly inequitable in terms of access.

Oral health workforce. Moving from inequitable private sector provision to equitable people-centred care will have big implications for the dental workforce as well as for the organisation of oral health care.

Role of civil society. The draft strategy correctly identifies civil society as being a key stakeholder in setting priorities for oral health care services and public health, and encouraging governments to develop ambitious national and subnational oral health responses. However, the draft strategy does not envisage WHO playing any role in strengthening such civil society mobilisation and advocacy. This needs to be strengthened.

Role of the private sector. This section (paras 63-66) is very weak. It sets out a series of 'private sector shoulds' without offering any suggestion that such redirections might need new drivers. There is no recognition of the magnitude of the challenge facing governments in integrating private sector providers within a coherent accountable organised system of prevention and care. This section needs to be strengthened.

4. Draft recommendations on how to strengthen the design and implementation of policies, including those for resilient health systems and health services and infrastructure, to treat people living with noncommunicable diseases and to prevent and control their risk factors in humanitarian emergencies

[EB148/7 Annex 9](#)

Doc [EB150/7 Annex 4](#)

The Board is invited to endorse the recommendations presented in EB150/7 Annex 4.

Public health and health care systems are stressed in situations of humanitarian emergencies. The nature and degree of such stress is a function of the nature of the emergency and the resilience of such systems.

Annex 9 of EB148/7 and Annex 4 of EB150/7 are both predicated upon the assumption that *"The health component of humanitarian responses to emergencies has traditionally focused on communicable diseases and injury management, with NCDs being poorly addressed"* (para 6, EB148/7 Annex 9).

Accordingly Annex 4 offers a range of actions for various stakeholders *"to strengthen the design and implementation of policies, including for resilient health systems and health services and infrastructure to treat people living with NCDs and prevent and control their risk factors in*

humanitarian emergencies, including before, during and after natural disasters, with a particular focus on countries most vulnerable to the impact of climate change and extreme weather events” (para 40 of UNGA Resolution 73/2).

PHM deplures this competitive, siloed approach to NCDs in the context of humanitarian emergencies. The core policy challenge is about the resilience of health systems in the face of emergencies. This includes monitoring all sectors of public health and health care and mobilising, as needed, reserve capacity in order to keep critical lines of service delivery operating. If, as is claimed in Annex 9 of EB148/7, NCDs have been ‘traditionally’ neglected (in comparison with trauma and communicable disease) in humanitarian emergencies then the problem lies in the monitoring and prioritising functions in the whole of system response to the emergency.

There are three main problems with this annexure:

First, it implies that the disruption of NCD services in emergencies can be managed independent of ongoing disruption of other services. In other reports to the EB, there is detailed documentation of the high levels of disruption of tuberculosis control, routine immunization, polio eradication work, maternal and child health, HIV, Neglected Tropical Diseases- and each of these take a huge toll as excess deaths, excess sickness and costs of health care. These should be dealt together as part of emergency preparedness and response.

Secondly, unlike maternal care, child immunization and disease control programs, interventions against NCD and mental health are not part of the very selective primary health care packages that exist in most countries. Nominally there may be a national program against all NCDs, but often such programs are not (by design) universal programs and have therefore very minimal coverage-restricted to a few centers and to patients who seek them out. This is used to check the box that a program is in place, but in practice the majority of those who need care either fail to access it, or do so at their own costs in the private sector. Preventing disruption often boils down to ensuring continuing medication for those few who were coming to the public hospital in the nearby city. But in many cases travelling to the public hospital for primary care for NCDs was never a viable option, and in the face of a crisis collapsed altogether. The first and foremost priority therefore is to roll out all the NCD control programs to scale, integrated with district health systems, such that screening, routine medication access and follow up visits occur with primary care provider close to community and there is continuity of care and good referral support where required. If this is in place, then one can meaningfully talk of response to a crisis. But for the millions for whom there is no such access to care for NCDs, who are already facing a crisis of access, a new crisis is hardly the context in which this can be corrected. The report remains completely silent on this issue, and goes about it as if the entire system is in place.

Third, the report repeatedly talks of WHO creating an essential NCD package or even NCD kit that can be applied in an emergency. This is the main task it sets for the WHO Secretariat and international partners. This is a flawed understanding and is setting the Secretariat up for failure. The concern is perhaps to lower the excess NCD mortality that will result from the disruption of essential services. For example, most countries have struggled to maintain renal dialysis services, or cancer chemotherapy services or even radiotherapy services through the

pandemic. It would have been unethical and unacceptable, if they had not done so. Simply put, any NCD care on the essential services list will have to be maintained during an humanitarian crisis, even if it is tertiary care. To the extent that such tertiary care is part of a universalised primary health care approach, it would be easier to sustain it during the crisis. It would not be possible to define a limited or selective package of NCD services that can be applied in the absence of a comprehensive primary health care system.

For all these reasons, PHM urges withdrawal of this Annex 4 from this agenda item 7 and suggests that it is re-positioned along with a more comprehensive review of health systems preparedness and health system resilience and how disruption of ALL essential health services could be responded to during a humanitarian emergency.

5. Progress in the implementation of the global strategy to accelerate the elimination of cervical cancer as a public health problem and in the achievement of its associated goals and targets for the period 2020-2030

Doc [EB150/7 Annex 5](#)

[EB146/9](#) - Accelerating the elimination of cervical cancer as a global public health problem

[WHA73.2 - Global strategy to accelerate the elimination of cervical cancer as a public health problem and its associated goals and targets for the period 2020–2030](#)

The Board is invited to note this progress report on the implementation of resolution [WHA73.2](#) on the global strategy to accelerate the elimination of cervical cancer as a public health problem

The program has three components:

- HPV vaccination for girls before the age of 15
- Screening and early detection- at least once before 35 years and once between 35 and 45 years - with treatment of pre-cancerous lesions.
- Treatment: of cancer and palliative care

Last year there has been a set back on HPV vaccination due to covid 19 pandemic. But the other problem is that there are constraints in availability of the vaccine due to the problems related to monopoly in manufacture and supply chains. It is now introduced in 111 countries but the proportion of the eligible population covered is only 13%.

The report spells out the uneven progress on all three components across regions and between countries of the same region.

As in the case of other NCDs, slow progress is related to the weaknesses of primary health care systems which were designed to deliver very selective healthcare services and are now unable to take on the considerable increase in workload that such mass immunization plus screening and pre-cancer treatment puts on the already resource-constrained facilities. It could do so if the trained work-force and budgetary allocation were increased, but quite often, that is not the case.

The other reason for slow progress in LMICs, as in the case of other NCDs, is the poor access to essential technologies required for diagnosis, for treatment and for vaccination.

6. Progress achieved on prevention and control of NCDs and the promotion of mental health

Doc [EB150/7 Annex 6](#)

[A66/10 Rev.1](#) - Comprehensive mental health action plan 2013–20201

[EB146/7 \(Annex 1\)](#) - menu of policy options and cost-effective interventions to promote mental health and well-being

This report is part of the commitment made in WHA 73 to present an annual report on progress made in control of NCDs (given in part 1 of the report) and progress made in control of mental health (given in part 2 of the report).

The Board is invited to note the report.

With regard to progress on NCDs, the news is disappointing. The Global Action Plan is failing. No country is on track to achieve its voluntary goals, and only a small number have even honoured their process commitments towards getting there. While there has been a reduction in mortality for the most common NCDs (except for diabetes), the premature mortality (proportion in the 30 to 70 age group) has been increasing. Globally out of the top ten causes of mortality, seven are due to NCDs: Ischemic heart disease, strokes, COPD, lung cancers, Alzheimers, diabetes and kidney diseases in that order. In low income countries three of the top ten causes of death are due to NCDs whereas in the highest income countries nine of the top ten are due to NCDs. But this does not mean lower incidence of NCDs in low income countries. It only reflects the fact that deaths due to communicable diseases remain high in low-income countries and overshadow deaths due to NCDs. When the risk of premature deaths due to NCDs is compared it is higher in low income countries, and lowest in high income countries with middle income countries falling in-between.

The section on national capacity assessment relates largely, if not entirely, to the ability of countries to provide treatment as measured by whether they have created governance structures and rolled out generic implementation processes like issuing guidelines etc. There is some useful data on integration of NCD control into universal primary health care programs, but this is very sketchy and inadequate.

Other than explicitly pointing out the failure to make progress, the report is incomplete and inadequate to monitor progress and guide corrective action.

One major gap is related to equity. There is no measure of inequity in outcomes or access to care either in country data or regional data.

The other, even more surprising omission is the failure to mention the risk factors of NCD and the actions taken and progress achieved in their reduction. This would include at least tobacco

and alcohol consumption, nutrition including obesity, dietary diversity, fibre, salt intake, physical exercise, exposure to pollution and so forth. Comparable data on risk factors we know is available from at least 2014 (from STEPS surveys) and action on these determinants is the thrust of the NCD control program as promoted in LMICs. Hence its omission is surprising.

We note that had these data been provided it would have shown that the prevalence of many of the risk factors is higher in the high income nations though risk of premature deaths from NCDs is lower in them - as compared to low income and low and middle income countries. One reason for this is that the current list of social determinants included in the NCD control program are only half the story. There are many more social and commercial determinants of health and ill health that need to be brought into visibility. Issues like stress due to unemployment, poverty, violence and the sheer difficulty of survival for the poor take a huge toll and lead to a high burden of NCDs; these 'risk factors' have not been given the attention that they need in the mainstream discourse on NCDs.

Part II Progress on Mental Health

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

This report relates to the [Comprehensive Mental Health Action Plan \(2013 to 2020\)](#) adopted by the 66th World health assembly and extended to 2030 by the WHA in 2019. This has ten targets and a number of indicators. The report points out that the extent of mental health problems is huge with almost one billion people having experienced at least one mental health problem in their life-time and 1 in 100 dying of suicide with a disproportionally high mortality in the young adult.

The good news is that 88% of countries responded to data collection on its implementation which shows a modest but significant increase in the number of countries having a stand-alone mental health policy (75%) and those in addition having a mental health law (54 countries). The bad news is that only in 25 percent of countries are mental health services part of the primary health care program, which would effectively mean little access for the majority of the population. The annex mentions initiatives taken to launch a program for suicide prevention, and to address mental health populations in special populations; for children with UNICEF, for those facing adversity as in conflict, for humanitarian settings, in the Covid 19 context and for autism. All of these seem to be in very early stages, more a statement of intent than actual on scale implementation.

Clearly as for other NCDs, prevention and care need to be embedded in a whole of system approach with rich linkages across the prevention, care and rehabilitation phases. Approaches based on purchasing commodified items of service do not work and expanding public health services through an extensive publicly funded primary healthcare network remains the only option. However, the prevailing ideology of market based reforms and the reluctance to spend on public services for the poor remain big barriers. Nonetheless, WHO's efforts to keep this on the agenda are most welcome and must be endorsed and supported by Member States and Global Institutions need to come forward to commit financial resources and human resources to this task.

7. Draft intersectoral global action plan on epilepsy and other neurological disorders in support of universal health coverage

Doc [EB150/7 Annex 7](#)

[WHA73.10 - Global actions on epilepsy and other neurological disorders](#)

The Board is invited to endorse this detailed (38 pages) 10 year action plan (2022 to 2031) drawn up at the direction of the WHA73 in November 2020.

The first part of the plan, sets out the dimensions of the problem: the 9 million deaths per year and the DALYs lost and the main neurological disease conditions that lead to this loss (strokes, migraine, dementia, meningitis), and in children, developmental disabilities. It also sets out the numbers affected by epilepsy and puts the treatment gaps for these conditions at 50 to 75%, meaning that only a quarter of those affected get the treatment they need. This backgrounder also describes the increased prevalence of these conditions in those with different vulnerabilities and those with disability. It describes the high costs of care and the preventable nature of many conditions and why the high levels of stigma and discrimination make it a health and human rights related issue. The neurological workforce is also very inadequate, and in low income countries it could be only 0.1 per 100,000 as compared to 7.1 per 100,000 in HICs.

The vision statement sets out three goals: the promotion of brain health, the prevention and treatment of neurological disorders and epilepsy, and the attainment of highest levels of health and human rights and functional abilities in those affected. All of this is well stated and PHM welcomes the attention this neglected area of health and healthcare is getting.

The action plan consists of five strategies. The first of these relates to governance and calls for advocacy, policy and legislation and more financing. Quite welcome. The third strategy on prevention of neurological disease by prevention of infection and trauma as well as promotion of brain health is similarly most welcome.

The real problem is with the second strategy where the whole of diagnosis, treatment and care is presented as part of UHC although the term is not clearly unpacked and can be interpreted in many ways. However, a reading of this strategy seems to construct care for neurological disease as a stand alone proposition which can look for points of synergy with other programs, but otherwise is a distinct package. This would be a prescription for failure. There is a need to see care for people with these conditions as part of a primary health care approach, with good organization of service continuity across levels and disciplines and with an adequately trained dedicated workforce for some functions and part of the front-line workers tasks for simpler functions like access to regular medication etc. (A detailed critique of why packaging into UHC will not help is given in the [PHM comment](#) on management of HIV, Hepatitis and STDs).

Curiously when it comes to Strategy 5, on the approach to the management of epilepsy the document reverts, quite correctly to PHC as its main and only approach. This is welcome. However, like all NCDs, success will depend a lot on the readiness of the government to invest in a workforce and a suitable density of facilities.

Strategy 4 relates to research and innovation and information systems. Again as reported for other NCDs and communicable diseases, the current approach does not address issues of how one averts monopoly pricing, promotes relevant innovation, and ensures adequacy of supply and equity in access, in an approach that is largely market driven.

8. Draft action plan (2022-2030) to effectively implement the global strategy to reduce the harmful use of alcohol as a public health priority

Doc [EB150/7 Annex 8](#)

[EB146/7 Add.1 - Consultation on global alcohol strategy](#)

[SAFER \(2018\) Alcohol control initiative](#)

[EB146\(14\) - Accelerating action to reduce the harmful use of alcohol](#)

[Global status report on alcohol and health 2018](#)

[Global action plan for the prevention and control of NCDs 2013–2020](#)

[Tracker links](#) to previous discussions of alcohol

The Board is invited to endorse the draft action plan. PHM urges it to do so.

This is a far reaching and carefully thought out action plan. The principles, action areas and suggested actions fit well together.

However, there are three important areas which need to be strengthened.

Commercial interests obstructing the implementation of effective alcohol control policies

The Action Plan recognises the role of alcohol producers, distributor and vendors in obstructing the adoption of effective alcohol control measures (see para 14).

Commercial interference takes many forms including political campaign contributions and revolving doors. Where governments gain significant revenues from alcohol taxation, finance departments may be reluctant to restrict consumption.

There is no section in the Action Plan which explicitly advises alcohol control advocates on how to counter commercial barriers to effective controls. However, in Action 2 (page 30, under Action Area 6) the Action Plan raises the possibility of a dedicated fund for reducing the harmful use of alcohol based on earmarked funding or hypothecated alcohol taxes. Such a provision would provide independent funding for social marketing, including social marketing directed at policy reform.

Trade agreement provisions provide another avenue for commercial interests to obstruct effective alcohol control policies (see para 45). The Action Plan is commended for its inclusion trade negotiations under Action 9 for WHO (Action area 2, page 17).

The continuing impacts of colonialism (and other structural oppressions)

There are several references to indigenous people among others with ‘special needs’ or vulnerabilities.

However, there is no consideration of the ways in which the legacies of colonial displacement and slavery are expressed in contemporaneous oppressions (including racism and marginalisation from the mainstream) and the ways in which personal and community despair are sometimes managed with harmful alcohol use. This is certainly not the only example of alcohol being used to palliate community despair.

Failing to acknowledge community despair as a sometime driver of harmful alcohol use has the effect of sanctioning such oppressions. Acknowledging despair as a driver points towards structural reform, including racial justice and reconciliation, as important items on the alcohol and public health agenda.

Treatment

The various approaches to the treatment of alcohol dependence is not given the attention it needs in the Action Plan.

‘Treatment’ can take as its subject, the individual, family, self-help group, or community. In essence it is about changing our subjectivities (identities, anxieties etc) in terms of where we fit within our social networks and broader society and finding new ways of functioning in those networks without depending on alcohol. Such an approach to ‘treatment’ blends into prevention.

The discussion of treatment, in terms of country actions under Action area 1, and WHO actions under Action areas 4 & 5 needs to be strengthened.

PHM urges the Board to endorse the Action Plan but with a request to strengthen it in relation to these three areas.

9. Draft recommendations for the prevention and management of obesity over the life course, including potential targets

[EB150/7 Annex 9](#)

[A70/31 Commission on Ending Childhood Obesity \(ECHO\) Implementation plan](#) and Decision [WHA70\(19\) Adopting the implementation plan](#)

[Tracker links to previous discussions of obesity/overweight](#)

The report in Annex 9, starts with an overview of the global prevalence of obesity and overweight; then reviews some earlier work on obesity by WHO; then sets out some general principles to guide policy actions; lists recommended actions for governments, other societal actors and WHO; and ends with a series of proposed targets.

This is a very disappointing report. Its authors have anticipated the objections of the food industry and curbed the reach of the report accordingly. The mid term evaluation ([A74/10 Add.1](#)) showed that WHO is failing to make an impact on NCDs generally and obesity in particular. [Fig 1](#) of the mid term evaluation provides clear evidence of policy failure in NCDs generally and nutrition in particular.

Huge transnational agrifood corporations constitute the biggest single obstacle to effective food regulation with their massive lobbying resources including campaign contributions and revolving doors. It is the supply chains which they control which are delivering cheap accessible highly processed, salty and energy-dense packaged foods, and which play a major role in driving obesity and overweight.

The best that WHO can offer in this document is para 41:

*Manufacturers **should** reformulate their products, particularly those intended for children (reducing sugar and salt content), and reduce portion sizes. ... Food distribution chains **might** facilitate the access to fresh products, particularly fruit and vegetables, and support their promotion through adequate product placement.*

This para could well have been written by the International Food & Beverages Alliance. Was the IFBA involved in producing this report?

Air brushing the ECHO Implementation Plan

Why, in the summary of previous WHO work, is there no reference to the ECHO Implementation Plan ([A70/31](#))? Para 13 mentions the report of the Commission on Childhood Obesity but there is no reference to the Implementation Plan which was endorsed in 2017 in [WHA70\(19\)](#).

Is the omission of the Implementation Plan because of the references in that Plan to nutrient profiling (NP) and the possible role of nutrient profiling in food labelling, and in taxation and marketing policies? Over the last few years the Geneva office and regional committees of WHO have endorsed a range of policy initiatives focused on the use of nutrient profiling. Of these the [PAHO model](#) appears to be the most stringent.

At the heart of nutrient profiling is the recognition that while salt, free sugars, saturated fat, and kilojoules mediate the pathogenesis of obesity, the vehicle which delivers them is highly processed and ultra processed packaged food. See [McColl, Lobstein and Brinsden \(2017\)](#).

The PAHO model classifies products as processed or ultra-processed if they are excessive in sodium, free sugars, sweeteners, total fats, saturated fats or trans fats. The PAHO NP model requires the mandatory labelling of processed and ultraprocessed prepackaged foods including specifying the content of these nutrients. Food control mechanisms that could use the PAHO NP model include: the establishment of restrictions on the marketing/promotion of unhealthy food and beverages to children; the regulation of school food environments; front of package warning labels; taxation policies to limit consumption of unhealthy foods; assessment or reexamination of agricultural subsidies; and the development of guidelines for foods provided by social programs to vulnerable populations.

It is time that the EB and the Assembly endorsed PAHO's nutrient profiling approach.

Protecting policy space for food regulation

Another egregious omission from the report is any reference to the need to protect the policy space needed to regulate food systems. There have been repeated warnings over the last two decades of the threat posed to the effective regulation of food systems, by member state disputes in the WTO (based on the Sanitary and Phytosanitary Agreement) and by Investor State Dispute Settlement (ISDS) provisions in plurilateral trade agreements, . There are health exceptions in the SPS Agreement and in many plurilateral agreements but to defend regulatory action in the dispute settlement forums requires high level authoritative endorsement of the principles informing such regulation, such as is provided to tobacco control by the FCTC.

Until food regulation is provided with this kind of high level protective umbrella the threat of trade disputes and the huge costs they can incur will continue to chill government enthusiasm for effective regulation.

There is only one reference to trade in this report, in para 18, which says that governments should address a wide range of issues, including 'finance and trade'. However, there is no explanation of how finance and trade impact on obesity or how governments might 'address' them.

WHO must redouble its involvement in the Codex Alimentarius Commission to drive the democratisation of food regulation.

Integrating obesity initiatives to other NCD programs and child nutrition

This annexure also lacks clarity on how addressing obesity would be linked to other NCD control strategies and child nutrition programmes. Primary health care strategies must be designed to ensure the necessary integration. There are specific challenges in such integration because there could be high levels of under-nutrition and stunting, along with lesser levels of obesity in the same community, even in the same individual, and both can be due to poverty and deprivation.

In most LMICs, under-nutrition leading to stunting and wasting remain the main problem. This problems has roots in both the quantity of food accessed by poor and marginalized populations *and* the quality or diversity of food that can be accessed. If household resources are only sufficient to access low quality energy, and more nutritious foods are missing, childhood obesity may mask under nutrition. The co-existence of stunting and obesity should alert public health authorities.

PHM urges member states to ask the Secretariat to explain the involvement of the food and beverage industry in the development of this report.

PHM urges member states to reject this annex and to ask the Secretariat to try again, a bit harder.

10. Draft workplan for the global coordination mechanism on the prevention and control of noncommunicable diseases

[EB150/7 Annex 10](#)

[WHA74\(11\) - The role of the global coordination mechanism on the prevention and control of noncommunicable diseases in WHO's work on multistakeholder engagement for the prevention and control of noncommunicable diseases](#)

Final evaluation of the WHO global coordination mechanism on the prevention and control of noncommunicable diseases (2020). [Report](#), [Annexes](#), [Executive Summary \(EB148/7 Add.2\)](#)

[A74/10 Add.1](#) - Mid-point evaluation of the implementation of the WHO global action plan for the prevention and control of noncommunicable diseases 2013–2020 (Executive Summary)

[Chronology of the consideration of NCDs by WHO governing bodies](#)

[Tracker links to previous discussions of the GCM](#)

The GCM was invented in 2013 as part of the Global Action Plan 2013-2020 in the Annex to [A66/9](#). The main aim of the GCM was to be (from [para 14 of the Annex](#)):

“... to engage with Member States, United Nations funds, programmes and agencies, international partners including academia and relevant nongovernmental organizations and selected private sector entities that are committed to implementing the action plan, while safeguarding WHO from any real, perceived or potential conflicts of interest ...”

Most of the reports which have been generated around the GCM are couched in indecipherable generalities reflecting negotiated text which conveys to all parties that their interests and policies have been recognised and advanced, notwithstanding profound differences. In a sense such documents are designed to ensure that nothing is achieved.

Two different interpretations of the GCM story can be told.

A regulatory interpretation of the GCM story. GCM was constructed as a member state instrument with a commitment to multisectoral and multistakeholder engagement for the prevention and control of NCDs. Member states would come together to explore strategies for encouraging whole of government responses to the NCDs challenge. Such responses would include engaging with the private sector. Such engagement could be cooperative, e.g. directed to promoting physical exercise or could be regulatory, including effective food labelling, fiscal policies, pricing incentives and the protection of policy space from investor protection agreement in trade agreements, etc. An unusual example of explicit text is found in the report of the [2014 Working Group on engaging with the private sector](#).

A food industry interpretation. The food industry offers self-regulation including producing a wider range of food products (reformulation) and marketing reduced portion sizes and so there is no need for any restrictive statutory regulation. Such a laissez faire interpretation is completely consistent with the generalities of the GCM.

The reports of the [preliminary](#) and [final evaluations](#) of the GCM are damning. It appears that very little has been achieved. The low level of member state engagement with the evaluations suggest that the GCM is not highly valued at the national level. Adverse outcomes at the global level include overlaps with the Inter Agency Taskforce and fragmentation of effort within the Secretariat.

Nevertheless, in [Decision WHA74\(11\)](#) the Assembly chose to extend the term of the GCM to 2030 although it also requested “more focused approach to the delivery of its functions, and with clearly defined objectives and measurable and practical milestones”.

The redirection required by WHA74(11) increases the focus on what member states are doing domestically which is probably a good idea.

The draft work plan presented in [EB150/7 Annex 10](#) continues the tradition of bland generality. It promises to develop new tools, a new guidance framework, capacity development, engagement, webinars, and consultations.

The bureaucratise rises to new heights of obscurantism in Priority Area 5 which is about “the meaningful engagement of people living with NCDs and mental health conditions”. The challenges of engaging with people with lived experience is very different for people with hypertension, chronic obstructive lung disease, lung cancer, heart disease or stroke than it is for people living with mental health conditions. However, because the bureaucracy has chosen to bundle these groups together, bundled they stand regardless of the significance of different specifics.

PHM calls on member states to unequivocally commit to effective national regulation of the junk food industry. The key modalities of such regulation are well known. The time is now for action.

PHM calls on member states to commit to a new international legal instrument that sets out clearly the standards which must be met by countries in their national food regulations. Such high level authority is critical for protecting the policy space needed for effective regulation at the domestic level in order to prevent regulatory chill arising from the threat of investor state litigation.

PHM calls on the WHO to re-configure the tasks of the Global Coordination Mechanism to address some cross-cutting issues that are equally important for all NCD control action plans. Most important of these is to develop a global compact by which essential drugs and diagnostics for these different programs are made available through pooled procurement linked to expanded and more robust form of the Covax program. In addition, on the lines of C-TAP, new drug innovation and the development of domestic manufacture of drugs and relevant diagnostics are also stepped up. Other systems strengthening initiatives that all NCD programs require are related to: a) integration into universal comprehensive primary healthcare systems

with referral support and continuity of care arrangements, b) better information systems including civil registration and vital statistics to guide programs, c) integrated workforce development policies to support such a massive expansion of services, and d) decentralized governance/district systems with active participation of communities.

This annexure is best withdrawn or rejected by Member States, and the GCM given a clearer mandate with a better focus and a road map by which it can make itself and the NCD action plans more effective.

8 Global health sector strategies on HIV, viral hepatitis, & STIs

In focus

In response to the request in decision [WHA74\(20\)](#) (2021), the Director-General submits [EB150/8](#) which outlines draft global health sector strategies on, respectively, HIV, viral hepatitis and sexually transmitted infections, for the period 2022–2030. The report sets forth the purpose, vision, goals, strategic directions and the framework for action and implementation of the strategies, which have been developed through a broad consultative process.

The Board is invited to consider the draft strategies and recommend their adoption to the Seventy-fifth World Health Assembly.

Background

[Tracker links to previous discussions of HIV, viral hepatitis, and STIs](#)

[Global progress report on HIV, viral hepatitis and sexually transmitted infections, 2021. World Health Organization, 2021](#)

[Full draft global health sector strategies on respectively, HIV, viral hepatitis and sexually transmitted infections, 2022-2030](#)

[WHO 2021 State of Inequality: HIV, TB & malaria](#)

PHM Comment

Excellent draft document

The draft global health sector strategies document is excellent. It takes a health systems approach rather than a disease focus although recognises the disease specific needs. Aspects to be particularly appreciated include the emphasis on community engagement, the commitment to harm reduction, and the repeated references to adapting the general strategies to national circumstances.

However, there is one deep contradiction, one critical absence and a number of areas which need to be strengthened.

Integrated and people centred health services not compatible with ‘universal health coverage’ as endorsed by WHO, the World Bank and the Rockefeller network

The contradiction arises in the repeated references to “universal health coverage” as a basic framework for the strategies. In parallel the strategies call upon ‘integrated and people centred health services’ and primary health care as basic frameworks. These are not compatible.

Notwithstanding the glossy marketing of UHC, the proposed pathways for implementation point towards a minimal safety net (the essential benefits package), publicly funded, delivered by public, private and voluntary service agencies and paid for through commodified purchasing mechanisms. Meanwhile, what the glossy brochures don’t advise is that ‘beyond the package’ services are to be delivered through a marketised health system financed through health insurance and delivered by an increasingly privatised fleet of service agencies. This is in essence the health system model that the World Bank has been pushing since 1993 but now with the support of WHO.

What the global health sector strategies document does not explain is how the integrated and people centred services which it foreshadows are to be ‘purchased’ as part of a ‘defined benefits package’ from a chaotic mix of public, private and voluntary agencies.

Many of the core commitments of these strategies are not compatible with such a funding system. Consider the kinds of community engagement involved in interrupting vertical transmission, in countering stigma, in supporting harm reduction measures for people using drugs. These, and many of the other excellent principles recommended in the strategies, require stable, well organised primary health care capacity with strong support and referral links to more specialised services and who have a close relationship of solidarity with the community. The community is a co-producer, a partner and not a customer or client purchasing services.

Action 22 deals with effective and inclusive governance: “Strengthen national governance structures and costed strategic plans to guide national responses to HIV, viral hepatitis and sexually transmitted infections, with meaningful engagement of communities and promoting synergies with broader health governance structures and plans, aligned with international human rights principles and standards.” The kind of system-wide approach that this para suggests is not compatible with the safety net plus private market approach being sold under the slogan of UHC.

Action 70 deals with ‘decentralized and differentiated viral hepatitis services’. “Viral hepatitis B and C interventions have traditionally been delivered through hospital-based tertiary services and by specialists. Achieving hepatitis elimination will require adoption of a public health approach using simplified service delivery protocols including decentralization of testing and treatment to lower level health facilities, including primary care, harm reduction sites or prisons, ideally with delivery of testing and treatment at the same site to promote linkages; integration of viral hepatitis testing and treatment services into existing primary health care, HIV, harm reduction, or prison health; and delivery of care and treatment by non-specialists including

primary care physicians and nurses with support from peer workers and patient navigators in some settings.” It stretches credibility to propose that this vision of a locally based person centred integrated system can be rendered as a purchasable package of ‘defined benefits’.

Social determinants of Disease:

Another critical weakness in this document is the lack of any mention of social determinants of these diseases and the preventive actions that are required to slow down and reverse these epidemics. While access to treatment is important and had been downplayed in the past, the pendulum should not swing to the side of now underplaying preventive action. For hepatitis A & E the prevention of water-borne infection is the key- and this is completely missing. The remaining diseases Hepatitis B, C, D; HIV and the STDs- are all sexually transmitted diseases with a well known set of social determinants- that includes the lack of awareness of safe sex, the powerlessness of women in many contexts in being able to demand or enforce safe sexual practices, issues of violence, displacement and conflict and social fragmentation, and different forms of social vulnerability and adolescent and young persons health and mental health issues. . Similarly intravenous drug use, another major channel of spread also has a set of social determinants that require to be addressed. Irrational care in private sector and unsafe injections and nosocomial spread are another preventable sources of spread. Mother to child transmission, especially in HIV is a huge problem, which potentially can be eliminated with adequate access to primary health care and supportive referrals. Access to primary health care, especially testing and counselling services is also in itself a social determinant.

The complete absence of any mention of these social determinants makes us concerned about the entire Global Health Sector Strategy that WHO is said to be developing and of which these are three chapters.

Neoliberal globalisation

It is not surprising that neoliberal globalisation is not mentioned in these strategies. However, it is the ‘ghost at the table’. There was an earlier time in WHO’s history when it was not so reticent about referring to the global economic relationships which frame, in so many ways, people’s access and health chances.

Neoliberal globalisation is a regime of unequal exchange, tax impunity, overproduction (and unemployment), financialisation (and widening inequality), and public sector austerity (while billionaires flourish).

The strategies document recognises (page 5) that: “HIV, viral hepatitis and sexually transmitted infections share modes of transmission and common interventions. They also are shaped in similar ways by social and structural determinants of health, such that people facing poorer socioeconomic conditions, or discrimination based upon gender or other identity markers, risk greater vulnerability to infection and worse health outcomes”. Astonishingly the passage goes on to say that, “Putting people at the centre of rights-based health system responses – by organizing services around people’s needs rather than around diseases, and by promoting

integrated patient-centred approaches and linkages with primary health care services – is the key to ending these epidemics”.

Poverty, alienation, racism, stigma, and various environmental exposures have deep roots in political and economic relationships and their histories. These ‘social and structural determinants of health’ need to be addressed in a rights-based framework but redressing the oppressions, exploitations and exclusions requires much more than this. Implementing such a framework will not happen unless the institutions, ideologies and power relations are also reformed.

Consider, for example, the hyper-incarceration prevalent in ‘post’ colonial settler societies where the continuing dynamics of colonisation and slavery are alive and powerful. Action 20 (p30) which deals with prisons and other settings correctly calls for equitable access to services in special settings, including prisons.

Production and innovation

A key target for these strategies is the availability of affordable, effective vaccines, diagnostics, drugs, and other health products, including protective personal equipment.

Treatment costs (especially for HIV and hepatitis C) are a major barrier to the achievement of the goals of these strategies. Likewise the supply and prices of point of care diagnostics and vaccines (for hepatitis B and HPV) are critical barriers to overcome.

Strategic Direction 2 addresses access to commodities. Action 24, from page 31, sets out an impressive range of generic strategies to promote access and control prices. Disease specific issues concerning commodities are discussed under Action 52 regarding HIV, from page 45; Action 72 regarding hepatitis, from page 57, and Action 95, from page 69, regarding STIs.

It would be a major step to implementation of the global health strategies if all of the initiatives listed in Action 24 were to be fully implemented, in particular, local public sector production of health care products and commodities, full use of TRIPS flexibilities, price transparency, and full use of pooled procurement (nationally or regionally). However, the Secretariat and its funders will need to be held accountable for full implementation.

Priorities for innovation are considered under Strategic Direction 5. Action 35, from page 36, sets out a range of strategies to drive innovation for health. Some of the disease specific priorities for innovation are set out in Actions 56-60, from page 47, regarding HIV; Actions 77-80, from page 59, regarding hepatitis, and Actions 102-105, from page 72, regarding STIs.

“

This is quite weak and completely bypasses the debate between upfront support for R&D versus market strategies based on private investment upfront with repayment dependent on intellectual property protection, high prices and high volumes. The Covid experience (like the ARV experience before it) demonstrates that the pharma (and diagnostics) companies will exploit to the full the flexibilities available to it under this market model.

The Covid experience points to the importance of ‘market strengthening’ policies such as building public sector R&D, and production, capacity in the global South. WHO should commit to exploring new approaches to funding R&D in accordance with GSPOA recommendations as well as new approaches to expanding local public sector production capacity.

In many countries the availability of affordable penicillin as a generic drugs for use against common STDs is becoming a problem, as commercial manufacturers and providers are preferring costlier alternatives. Ensuring adequate supplies of penicillin in public health facilities has thus after decades once again become challenge.

WHO’s role in implementation

Section 7.3 which outlines what the WHO Secretariat will do as part of the implementation of the strategies is dense with admirable ‘WHO will ...’ statements. However, it is not clear how WHO will be held accountable for these and how its donors will be held to account for their funding. Given WHO’s egregious dependence on donor funding there needs to be stronger mechanisms for holding the Secretariat and its donors accountable for delivering on these ‘WHO will ...’ statements in S7.3. Annex 2(e) (page 102) provides a framework for monitoring the work of the Secretariat. However, the indicators listed do not cover all of the ‘WHO will ...’ statements in Section 7.3.

Implementation of these strategies is not just about what ‘countries’ decide. Rather it will depend on subnational and local policy officials, health service managers and practitioners as well as community activists. Action E (page 77) promises that “WHO will strengthen its work at country level as a technical support partner for policy development, strategic planning and implementation of national HIV, viral hepatitis and sexually transmitted infection responses with effective involvement of communities in decision-making and service delivery. WHO will also support countries to strengthen public health institutions and build health system capacity.” WHO’s country offices must be empowered to reach out directly to professional and community organisations to support this transformation.

9. Global strategy: TB research and innovation

In focus

In [EB150/9](#) the EB is invited to note progress: (i) in relation to the [End TB Strategy](#); and (ii) in relation to the implementation of the [Global strategy for tuberculosis research and innovation](#) which was adopted in [WHA73.3](#) (2020).

Consideration at EB150 and WHA75 will feed into a planned United Nations high-level meeting on tuberculosis in 2023.

Background

See [Tracker links to previous discussions and decisions](#) re TB, Ending TB and TB research and innovation.

See [Tracker links to previous WHA resolutions about TB](#)

[WHO 2021 State of inequality: HIV, tuberculosis and malaria](#)

PHM Comment

The Director General's Report indicates that there have been huge setbacks to every dimension of the TB control programme. The end TB strategy that was already off course is going to find it nearly impossible to reach its modest 2025 targets.

The setbacks in TB control associated with Covid underscore the complete lack of health systems preparedness across most countries and a poor understanding of what it means to build resilience health systems. It is important henceforth to ensure that one of the essential definitions of resilience is the ability to continue to provide essential health services, especially tuberculosis services without disruption. We also note that there are many countries that did manage to limit or eliminate such disruption, often due to the work of dedicated TB officers, and one must learn from this. Countries with more robust, well staffed primary healthcare networks, and those with adequate community health workers and community engagement have done better. Disruption of essential health services in a pandemic is not inevitable. Its poor planning and poor design, where public services are designed for minimal packages with minimum staff and have been deliberately undermined in the name of health sector reform and universal health coverage. Shifting from provisioning of services to purchasing of services in the name of increasing coverage has not helped increased access during this crisis as private services collapsed more completely and for longer periods than public providers.

The Report must acknowledge disruption of TB services as a preventable feature, and not deal with it as if it was inevitable. Further the lack of solidarity in the global pandemic response, in particular, the restrictions on vaccine supply (from vaccine hoarding and imposed limits on

production) has also delayed social recovery from the pandemic- and as the pandemic continues so does the disruption of TB control services.

TB is the paradigm indicator of poverty and marginalisation, mediated in particular, by housing and nutrition (see refs below) and out of pocket costs for care. However, while housing and nutrition are mentioned as risk factors, there is nothing about researching poverty and marginalisation in the Global Research and Innovation Strategy and there is certainly no recognition in the [End TB strategy](#) of the global regime of unequal exchange which reproduces widening economic inequality within and between nations. There is also no mention made of the fact that because of a pandemic related worsening of all known social determinations- under-nutrition, worsening of poverty and marginalization, displacement, incidence of TB is likely to rise and taken along with the reduction in case detection activity is likely to lead to an acceleration of TB incidence. Further combined with treatment continuity gaps, drug resistance is also likely to increase. Drug resistance is driven in part by lack of universal access to care.

The Report also notes that 47% of the population on treatment for tuberculosis experienced catastrophic health expenditure- an increase from earlier times. Budgets for TB control, already less than 50% of required levels, fell further.

WHO has recognised the importance of civil society in driving action for health but in relation to TB it has individually selected a group of 'civil society representatives': the [WHO Civil Society Task Force on TB](#). It seems directed to restricting the focus to TB and avoiding any focus on the global regime of unequal exchange and widening inequality.

Budgets for TB related research and innovation have also dropped and are less than half the estimated requirement. Further no new drugs, vaccines, or diagnostics are in immediate sight. There is clearly a failure of the IP-Protected-Profit-based incentive model of pharma innovation.

The WHO is moving towards a comprehensive review by Heads of State and Government at a United Nations General Assembly high-level meeting on tuberculosis in 2023. PHM calls for a much closer communication between civil society organizations and WHO and UN agencies in the build up to this review and the action plan that emerges from it. Tuberculosis is the second largest killer amongst infectious disease, second only to covid 19. The arguments for waiver of all patents for covid 19 related technologies must be extended to all TB diagnostics and drugs, and PHM calls for this to be put on the agenda of the planned UNGA high level meeting on tuberculosis in 2023.

References

Bhargava, A., M. Bhargava and A. Juneja (2021). "Social determinants of tuberculosis: context, framework, and the way forward to ending TB in India." *Expert Review of Respiratory Medicine* 15(7): 867-883. <https://doi.org/10.1080/17476348.2021.1832469>

de Alencar Ximenes, R. A., M. de Fátima Pessoa Militão de Albuquerque, W. V. Souza, U. R. Montarroyos, G. T. N. Diniz, C. F. Luna and L. C. Rodrigues (2009). "Is it better to be rich in a poor area or poor in a rich area? A multilevel analysis of a case-control study of social

determinants of tuberculosis." *International Journal of Epidemiology* 38(5): 1285-1296. <https://doi.org/10.1093/ije/dyp224> Accessed 12/21/2021.

Ghose, B., Z. Cheng and Z. He (2014). "Understanding the social determinants of TB and HIV in South Asia." *PeerJ PrePrints*. <http://dx.doi.org/10.7287/peerj.preprints.579v1>

Hargreaves, J. R., D. Boccia, C. A. Evans, M. Adato, M. Petticrew and J. D. H. Porter (2011). "The Social Determinants of Tuberculosis: From Evidence to Action." *American Journal of Public Health* 101(4): 654-662. <https://doi.org/10.2105/AJPH.2010.199505> Accessed 2021/12/21.

Zakoji, Masahiro, and T. Sundararaman. 2021. "Emerging Good Practices and Lessons Learnt to Maintain Essential Health Services during the COVID-19 Pandemic." *WHO South-East Asia Journal of Public Health* 10 (3): 26., March 21, 2021 Available from: <http://www.who-seajph.org/text.asp?2021/10/3/26/309868>

10. Roadmap for NTDs 2021-2030

In focus

[WHA73\(33\)](#) (2020) endorsed the new road map for neglected tropical diseases 2021–2030 and requested biennial reports on the implementation of the road map. [EB150/10](#) is submitted in response to that decision.

Different versions of the Road Map:

- [Road map for NTDs - 2021–2030 \(full, 14.5 mb\)](#)
- [Road map for NTDs - 2021–2030 \(overview\)](#)
- [A73/8 - DG report to WHA73 on draft road map](#)

EB150/10 reports on each of the three pillars of the road map.

Under 'Accelerate programmatic action' the report reviews various indicators against targets and notes the disruptions associated with Covid and how these have been managed.

Under 'Intensify cross cutting approaches' the report describes activities under the four cross cutting approaches: integration among NTDs (eg skin, food safety); mainstreaming into national health systems; coordination with relevant programmes such as vector control, WASH, One Health, and other programmes; and delivery through strong country health systems.

The third pillar is 'Change operating models and culture to facilitate country ownership'.

Background

See WHO [topic page on NTDs](#)

See WHO's [NTDs Control Team page](#)

See [Tracker links to previous EB/WHA discussions of NTDs](#)

Vector control

EB150/10 notes the Global Vector Control Response 2017–2030, welcomed by the Seventieth World Health Assembly in resolution WHA70.16 (2017) and reports that a Joint Action Group is coordinating the implementation of this strategy at regional and country levels.

Social determinants

Not so well covered in the Road Map. See Aagaard-Hansen, J & Chaignat, CL 2010, 'Neglected tropical diseases: equity and social determinants', in Erik Blas and Anand Sivasankara Kurup (eds), *Equity, social determinants and public health programmes*, WHO, Geneva, pp. 135-57,

<http://apps.who.int/iris/bitstream/handle/10665/44289/9789241563970_eng.pdf#page=145>.

Calls for six actions:

Action 1: Addressing water, sanitation and household-related factors (the “preventive package”).

Action 2: Reducing environmental risk factors.

Action 3: Improving health of migrating populations.

Action 4: Reducing inequity due to sociocultural factors and gender.

Action 5: Reducing poverty in NTD-endemic populations.

Action 6: Setting up risk assessment and surveillance systems.

The political economy of the global NTDs ‘system’

Lot of talk about the “NTD community”. Appears to include: [NTD NGO Network](#) (strong presence of Northern charities) and [Coalition for Operational Research on NTDs](#) (funded by Gates and UK). Clearly includes also the pharmaceutical companies who donate medicines (6b pills). Not sure if it includes the communities who carry the burden of neglect.

PHM Comment

The Road Map (full) is very useful in many ways. However, the framework adopted is designed to encompass the specificities of ‘neglected tropical diseases’ within one framework rather than the specificities of individual countries, none of whom confront the full hand of all 20 NTDs.

Notwithstanding the references to cross cutting approaches, it seems that mass drug treatment remains a central modality with less focus on action on the social determination of NTDs. Also though the NTDs share some of the social and environmental determinants, these are very varied diseases requiring very different types of road-map and response. Some of them like leprosy and snake envenomation carry high level of morbidity or mortality. Leprosy is far from elimination despite very optimistic claims and is going to require sustained action over a long period.

It is hard to gauge progress on country ownership from this report. Progress with many NTDs will require integration into the primary healthcare system and the network of public primary care providers and frontline workers. But this is neither highlighted as a gap, nor reported upon as an indicator of progress. Some diseases like snake envenomation require higher levels of primary care, emergency response and tertiary care and much better drugs and diagnostics.

There is very little discussion on the adverse impact that covid 19 has had on NTD interventions. From reports from country circles and published reports we know that this may be one of the hardest hit among all essential health programs.

For many of the NTDs, the OneHealth approach is essential to prevention. But what it could mean would vary widely across diseases. Strategy development in this area remains a challenge.

It would also be important for the report to point out diseases where new drug and diagnostic innovations are urgently required, as different from situations where effective drugs are available, but the challenge is access.

11. Immunisation agenda 2030

In focus

In [WHA73\(9\)](#) (2020) the WHA endorsed the new [Immunization Agenda 2030](#) and requested the DG to continue to monitor progress and to report biennially as a substantive agenda item to the Health Assembly, starting with the Seventy-fifth World Health Assembly.

The [draft global report](#) (NYP) on the Immunization Agenda 2030 for 2021 is still not published (as of late December 2021) but is summarized in [EB150/11](#).

Background

See [Immunisation Agenda 2030](#) home page and [Monitoring and Accountability Framework](#) and [Annex 2: IA2030 Ownership and Accountability Global Level Partnership](#)

See [WHO topic page](#) on vaccines and immunisation and [WHO teams page](#) for immunisation, vaccines and biologicals

[WHO guide for standardisation of economic evaluation of immunisation programs](#) (2nd Ed, Oct 2019)

[Tracker links to previous discussions and decisions](#) and [Tracker links to previous resolutions](#)

PHM Comment

The Immunisation Agenda 2030 (IA2030)

PHM appreciates the several strengths of IA 2030, the three goals, the four core principles and the seven strategic priorities. We welcome the establishment of the working groups which will continue to inform development and implementation.

However, there are structural weaknesses embedded in the Agenda which reflect wider flaws in contemporary global health governance more generally.

Multistakeholderism replacing multilateralism

The dominant role of USAID, the Gates Foundation (and GAVI), and a range of voluntary and private sector organisations in the development and management of IA2030 reflects the continuing drive by the US and its allies to marginalise WHO and therefore its member states and to entrench a leading role for the bilateral donors, philanthropic foundations and the private sector in global health governance (and in the management and coordination of the Agenda).

In view of this marginalisation of WHO (and the countries who own it), the repeated references to 'country-owned' is risible. Having bypassed the member states in developing the Agenda, the

challenge of building country ownership is recognised. See IA2030, p57, “A mechanism *will be necessary* to ensure ownership accountability and definition of the roles and responsibilities of all stakeholders in delivering IA2030 vision and strategies. This will be a key objective in the second phase of IA2030 development.”

The UHC deception and opportunistic references to PHC

There are repeated references to the deeply flawed policy of universal health coverage and a bowdlerised version of PHC as the basis for IA2030 (with the USAID in charge - see Annex 4 to EB150/11).

Despite the rhetoric, the model of UHC which is being promoted through WHO, the World Bank and a range of ‘partners’, is essentially that promoted by the WB in 1993: a minimal safety net based on a defined benefits package, marketised service delivery including the safety net, and funding via health insurance. This will not deliver universal health care and will make the goals of the IA2030 much harder to achieve.

PHC delivered through private providers as part of an essential benefits package is mooted as the platform for immunisation including building trust for immunisation though there is little evidence of this working, On the other hand the strengthening of public services does not have the necessary emphasis; the critical (potential) role of CHWs in comprehensive PHC is also missing.

Vaccine innovation, production and procurement

The strategies relating to vaccine innovation, regulation production and procurement are lacking. There is:

- a lack of action on technology sharing which might be critical in fully deploying TRIPS flexibilities for vaccine procurement;
- a lack of action on vaccine price transparency; several references to “healthy market dynamics” seems to mean that producers must be assured of high prices;
- a failure to recognise that the opportunity costs of including new vaccines on the national schedule are a function of competing needs and comparative costs as well as fiscal capacity;
- a failure to call for strengthening regional collaboration for pooled procurement; and
- inadequate provision for strengthening the technical capacity and public accountability of NITAGs and RITAGs.

Promising universal vaccine coverage while defending an increasingly unequal global economic regime

Not surprisingly, given its sponsors, the IA2030 fails to acknowledge the contradiction between the immunisation goals and consequences of a global economic regime based on unfair and unequal exchange, driving widening economic inequality, climate change (and related ‘natural’ disasters), unplanned urbanisation, conflict and lack of fiscal capacity.

The Agenda fails to note and draw the right lessons from the high degree of inequity in covid 19 vaccine coverage between regions and within countries. While WHO has correctly called out and condemned this inequity as “vaccine apartheid”, the structural reasons for inequity in covid 19 vaccine coverage or no different from those for coverage in routine immunization as well and relates to inequity in design of health systems which compounds inequities imposed by vaccine markets.

The Agenda fails to acknowledge how widespread grievance and alienation, arising the transformations of globalisation are contributing to vaccine resistance. Not surprising that it also fails to acknowledge the role of neoliberal capitalism in generating inequality, grievance and alienation.

No budget

Despite talk of monitoring and accountability the sources, pathways and sinks underpinning the financing of the Agenda are quite obscure. See paras 2.25-2.27.

Report on progress (EB 150/11)

EB 150-11 conveys clearly and frankly the huge setback to implementation of the immunization strategy across all dimensions due to Covid including the barriers to access and logistics as well as due to the shifting away of immunization staff to Covid 19 duties.

This was neither natural nor inevitable. Better health systems preparedness and better systems design and better pandemic response strategies could have averted it. Countries with robust primary health care programs and adequate workforce of frontline health workers and community health workers, and better logistics systems and better health management information systems in place did better. This disruption is partly the price that is paid for developing immunization strategies as vertical stand-alone strategies with poor integration to a strengthened primary healthcare system.

Shaping the IA2030

PHM urges member states to maintain a close watch over the structural deficiencies listed above and to ensure that they are mitigated and repaired as far as possible during the implementation of the Agenda.

12. Infection Prevention and Control

In focus

[EB150/12](#) reports on the spread of infection and antimicrobial resistance in health care facilities and its impact, and on the global situation of programmes for infection prevention and control at the national and facility levels, including gaps and challenges.

The report also provides an overview of WHO's recent activities on infection prevention and control and will propose some priorities and actions aimed at improving associated programmes. The Board will be invited to note the report and provide further guidance.

PHM Comment

This report largely pertains to infection prevention and control within healthcare settings- preventing hospital acquired infections and as a sub-set of that anti-microbial resistance quite clearly describes the extent of the problem. The report also describes the nexus of this problem with the Covid-19 pandemic. Lack of adequate infection prevention and control led to high levels of what were preventable infections of healthcare workers and of spread to patients coming to seek healthcare for other ailments.

The Report should have also emphasized that a considerable part of the disruption of essential non-covid health services was due to fear of covid 19 transmission, and could have been limited to a large extent if not altogether prevented if infection control protocols were in place and hospital and healthcare managers were confident of its effectiveness. Henceforth all emergency health care preparedness with reference to future epidemics and pandemics requires to emphasize this aspect. This should also be part of the understanding of building resilient healthcare systems.

The discussion of prevention of AntiMicrobial Resistance is seriously defective - as it fails to note several key aspects.

Most of anti-microbial resistance comes from forms of veterinary practice where antibiotics are abused in pursuit of increase of productivity and profits without reference to the ecological effects that such antimicrobial overuse has. This aspect of OneHealth finds no mention. Zoonotic disease transmission as part of disease surveillance also finds no mention.

A considerable part of antimicrobial resistance, at least in LMICs come from irrational and excessive prescription of antimicrobials due to the commercial nature of healthcare provision in the private sector. This becomes a culture that rubs off on to public providers also. Much of this can be attributed to the promotion of irrational prescription by marketing units of pharmaceutical agencies. One particularly dangerous form this takes, is the use of second and third level antibiotics meant for more restricted use as first line of anti-biotics- merely to give a quick result in an overly competitive clinical care market.

When talking of infection prevention and control- it is not only excess/irrational use that is the problem. Access to essential antibiotics is the bigger problem in most LMICs. That lack of access to basic antibiotics goes along with excess, wasteful and harmful use of anti-biotics is reflective of the commodification of medical care and requires to be reversed.

A lot of such over-use of antibiotics is also due to the lack of anti-microbial use stewardship. Antimicrobial culture and sensitivity studies are infrequent and unreliable and quite often unavailable for individual patients . They ought to be available at least in every district hospital, but this is far from the situation on the ground. Further even for community level frontline use, patterns of antibiotic sensitivity in different geographies and age groups are to be part of a surveillance with feedback as guidance to prescribing providers.

The report does emphasize the more frequent causes related to “low compliance with hand hygiene and aseptic technique practices, contaminated medical equipment and supplies, inadequate environmental cleaning, lack of trained infection prevention and control professionals and limited opportunities for staff training, exceeded bed occupancy, understaffing and limited or suboptimal infrastructure for patient isolation”

Ensuring that these gaps are closed, must require that every hospital, public and private have quality improvement and accreditation processes that ensures that this is done, and that the information on achievement in this regard, facility by facility is available in the public domain.

13 Global road map on defeating meningitis by 2030

In focus

In [WHA73.9](#) (2020) the Assembly approved the [global road map on defeating meningitis by 2030](#) (summarised in [A73/6](#)) and requested the DG to submit a report to EB150 on progress in implementing the resolution. [EB150/13](#) provides a summary of WHO activities since November 2020.

[EB150/13](#) reports on the current workplan and draft workplan for 2022-23; regional landscape analyses; consideration of using the levers from the [Operational Framework for PHC](#) in relation to meningitis; development of a monitoring and evaluation plan, and the development of a business case for funds mobilisation.

Background

The road map sets a comprehensive vision for 2030 “Towards a world free of meningitis”, with three visionary goals:

- Elimination of bacterial meningitis epidemics;
- Reduction of cases of vaccine-preventable bacterial meningitis by 50% and deaths by 70%;
- Reduction of disability and improvement of quality of life after meningitis due to any cause.

It sets a path to achieve goals, through concerted actions across five interconnected pillars:

- Prevention and epidemic control focused on the development of new affordable vaccines, achievement of high immunization coverage, improvement of prevention strategies and response to epidemics;
- Diagnosis and treatment, focused on speedy confirmation of meningitis and optimal management;
- Disease surveillance to guide meningitis prevention and control;
- Care and support of those affected by meningitis, focusing on early recognition and improved access care and support for after-effects from meningitis, and
- Advocacy and engagement, to ensure high awareness of meningitis, consideration into countries' plans, and increase the right to prevention, care and after-care services.

See [Fig 2](#) of the road map for the underlying theory of change.

[WHO topic page on meningitis](#); see esp [Defeating meningitis by 2030](#)

Recent commentary:

Stuart, JM 2021, 'Editorial for the Special Issue: Bacterial Meningitis—Epidemiology and Vaccination', *Microorganisms*, vol. 9, no. 5. <<https://www.mdpi.com/2076-2607/9/5/917/htm>>

Venkatesan, P 2021, 'Defeating meningitis by 2030: the WHO roadmap', *The Lancet Infectious Diseases*, vol. 21, no. 12, p. 1635, <<https://www.sciencedirect.com/science/article/pii/S147330992100712X>>.

[Tracker links to previous discussions of meningitis](#)

PHM Comment

Importance of comprehensive primary health care

There are three pillars of the road-map to meningitis control: disease surveillance, treatment, and vaccination and outbreak response. All of these depend a lot on the “use of the primary health care levers of the operational framework for primary health care for action on meningitis”, which includes the challenge of integration of meningitis prevention and management in primary health care.

The reason that meningitis is now figuring in the global public health program list is that vaccines are available for the four main causes of bacterial meningitis that have epidemic potential and that account for more than 50% of all deaths due to meningitis.

Meningococcal disease (meningitis and other presentations such as septicaemia) needs to therefore find a prominent place in disease surveillance systems. Disease surveillance systems need to be much more robust both in reporting suspect cases and in clinical and laboratory confirmation and outbreak response. Since the number of bacteria that cause meningitis is high, good laboratory support to identify the specific pathogen is essential.

Early diagnosis (usually based on clinical presentation), prompt treatment (penicillin) and outbreak response rest upon having in place an adequate primary healthcare system. Meningitis is not included in the selective list of conditions that are included in the primary healthcare package of most nations. Nor would it be possible to include it in such ‘packages’ in isolation from diseases with similar presentations.

Inclusion of meningitis in the list of public health priorities would require the strengthening of primary health care services and of clinical and laboratory support at district level.

Preparedness to deal with meningitis epidemics must be integrated into the epidemic preparedness effects that are being envisaged as a follow up to the covid 19 pandemic- and not as a stand-alone program.

Immunisation policy reform

Immunisation plays a key role in the road map and accordingly [PHM's commentary on Item 11 at this EB](#) is also relevant to Defeating Meningitis. Our comment on Item 11 highlights:

- failure of the profit driven R&D model for vaccine development; see discussion of innovation needs under Section 3 Prevention and Control [from page 14 of Baseline Assessment](#) from 2019; though there are vaccines available, further development is required to make better vaccines which can provide effective protection against all the main bacterial pathogens.
- need for technology transfer regarding vaccine production to enable local public sector production which might be critical in fully deploying TRIPS flexibilities for vaccine procurement (hinted at in the Road Map) and for stockpiling;
- lack of a strategy to control vaccine prices, including through price transparency; several references to “healthy market dynamics” seems to mean that producers must be assured of high prices;
- failure to recognise that the opportunity costs of including new vaccines on the national schedule are a function of competing needs and comparative costs as well as fiscal capacity;
- importance of strengthening the technical capacity, information support and public accountability of NITAGs and RITAGs; in order to carry out such cost effectiveness studies;
- strengthening regional collaboration for pooled procurement and stockholding for epidemic needs;
- dangers of multistakeholderism, handing over control to the corporations and their supporters and the foundations .

Stockpiles and emergency procurement

Ideally once an outbreak is alerted, the causative agent and its serotype has been identified and then the corresponding vaccine accessed from the nearest national (or international stock-pile) and the population at risk is to be vaccinated. Since the outbreaks occur in some of the most deprived and under-developed countries and regions, the importance of response from a global team maintaining stock-piles cannot be overstated. The Report does not present any details of the current state of readiness.

14. Standardisation of medical devices nomenclature

In focus

WHO has been discussing the standardisation of medical devices nomenclature since EB145 in May 2019. The goal is to have an open standardized international classification, coding and nomenclature for medical devices that would support: patient safety; access to medical devices for universal health coverage; emergency preparedness and response; efforts to increase quality of health care.

WHO is not working towards a new nomenclature system, but working towards harmonisation of the four most widely used nomenclature systems in accordance with WHO principles of governance, transparency and access.

Raw results from the 2021 survey of countries' medical device nomenclature systems is presented in the [Draft 2 Overview](#) and will be published in [EB150/14 Add.1](#) (not yet published).

[EB150/14](#) report provides details of the Secretariat's continuing work towards convergence and harmonisation in this area. The proposed first step would be a feasibility study on the challenges and benefits of using innovative mapping techniques to allow information from four of the most widely used nomenclatures to be publicly available on WHO platforms for use by Member States as a way towards standardization.

The Secretariat seeks a decision from the EB which would endorse continued mapping and collaboration with various stakeholders and a progress report for WHA76 in 2023.

Background

The four nomenclature systems, used by more than one Member State, are:

- the (open, EU sponsored) European Medical Device Nomenclature ([EMDN](#)),
- the (not-for-profit but pay-walled consortium) Global Medical Devices Nomenclature ([GMDN](#)),
- the (privately owned, pay-walled, US based) Universal Medical Devices Nomenclature System ([UMDNS](#)), and
- the United Nations Standard Products and Services Code ([UNSPSC](#)).

[EB145/3](#) explained the need for a standardised nomenclature thus:

6. A standardized classification and nomenclature of medical devices will serve as a common language for recording and reporting medical devices across the whole health system at all levels of health care for a whole range of uses. Such a classification would support patient safety, allow comparisons and measurement of the availability of medical devices as well as assessment of access to devices in the community using health facility

assessments tools. Standardization of nomenclature is also essential for defining and naming innovative technologies, classifying the devices for regulatory approval (registration) and for streamlining procurement of these products. The standardized naming of medical devices is required when describing the devices needed for the benefits packages for universal health coverage and it would also support common referencing in electronic health records and other health information systems.

These ‘needs’ have not been critically analysed in any of the documents so far produced by the Secretariat, nor has there been any exploration of the role device nomenclature plays in these functions, or why a standardised nomenclature will better facilitate these functions.

The reference to **patient safety and quality of health care** appears to refer to the role of standardised nomenclature for regulatory approval (implying mandatory registration) and in the assessment of levels of access to devices across facilities. International standardisation would support regional device regulation and regulation by reference to an international system of qualification.

A standardised nomenclature **will facilitate procurement** both for the supply officials ordering devices and for international corporations seeking to avoid having to adapt their catalogues to national differences.

The reference to **universal health coverage** appears to envisage the use of a standardised nomenclature in specifying ‘essential benefit packages’. Clearly the global UHC donors would prefer to have an internationally standardised nomenclature to facilitate the operations of benefit packages imposed on LDCs. Presumably the approved devices will be listed in [WHO’s UHC Compendium](#) of services and programs.

See [Tracker links to previous discussions of medical devices and health technologies](#)

PHM Comment

Standardised nomenclatures are useful. There are potential benefits to be gained from an internationally standardised nomenclature.

However, PHM has some concerns about the purposes of the current exercise and possible uses of an international standardisation:

- UHC as a minimal safety net under a privatised and marketised mainstream;
- imposition of restrictive standards which advantage transnational suppliers over local suppliers.

The purposes and uses of international standardisation have been assumed rather than analysed in the discussion so far.

See PHM comment on [Item 11 at EB148](#)

15.1 Strengthening WHO preparedness for and response to health emergencies

In focus

The board will consider two documents under this item:

- the DG's report ([EB150/15](#)) on what the Secretariat is doing to strengthen WHO's preparedness and response to health emergencies; and
- the interim report, [A/WGPR/6/3](#), of the Working Group on Strengthening WHO Preparedness and Response to Health Emergencies ([WGPR](#)) which canvasses proposed actions for the Member States, WHO Secretariat, and non-State actors directed to strengthening emergency preparedness and response.

Background

In [EB150/15](#) the Director-General reports, pursuant to resolution [WHA74.7](#) (2021), on implementation of [para 9](#) of the resolution (with 32 subparagraphs), as well as Secretariat support provided to the Working Group ([WGPR](#)).

Apart from the logistical support provided to the WG, the secretariat has developed the [Dashboard of Covid-19 related Recommendations](#) and has produced three reports to support the work of the WG:

- [A/WGPR/3/3](#) on WHO's collaboration with other entities in the United Nations system that operate during a health emergency;
- [A/WGPR/3/4](#) provides an overview of the funding mechanisms that have been applied to the COVID-19 response; and
- [A/WGPR/3/6](#) provides an analysis of incentives for a new instrument on pandemic preparedness and response, and on the options for strengthening the effectiveness of the International Health Regulations (2005) and options for creating a new instrument.

The Board will be invited to note EB150/15 and provide further guidance.

It was anticipated ([EB150/1 \(annotated\)](#)) that pursuant to resolution [WHA74.7 \(2021\), paragraph 6](#), the Director-General would (in EB150/16) transmit to the Board the report of the WGPR with proposed actions for the Member States, WHO Secretariat, and non-State actors, as appropriate, for consideration by the Seventy-fifth World Health Assembly.

(The first report of the WG, responding to the mandate given in WHA74(12), recommended the establishment of an International Negotiating Body (INB) to develop a new legal instrument. This was accepted by SSA2 and the INB is presently being assembled. The progress of the INB will be considered under Item 3 on the EB150 agenda. See [PHM commentary on this item.](#))

In fact, the WG has not finalised its research and deliberations and as of 17 Jan the document identified as EB150/16, which was to transmit to the Board the final report of the WGPR, has not been posted. However, the WGPR has published an interim report, [A/WGPR/6/3](#), for consideration by EB150. Its final report, to be submitted directly to WHA75, will be finalised in early May 2022.

Presumably the Board will discuss and note the report in [A/WGPR/6/3](#) and may choose provide further guidance.

See also report of regional committee discussions of the recommendations of the Working Group on WHO Preparedness and Emergency Response in [EB150/4](#) (paras 12-15).

PHM Comment

See PHM comment on the report in [A/WGPR/6/3](#) in our comment on Item 3, [here](#).

The DG's report [EB150/15](#) summarises the steps taken by the Secretariat, to strengthen WHO's preparedness and response to health emergencies, under three headings:

- countries prepared for health emergencies;
- epidemics and pandemics prevented; and
- health emergencies rapidly detected and responded to.

PHM commends the Secretariat for the intelligent and strategic approach it is taking to strengthening its emergency preparedness and response capacity as set out in paras 3-21 of EB150/15.

However, PHM urges member states to provide further guidance directed to:

- Addressing the full range of issues associated with research, innovation, and production of medical products needed in an emergency, including capacity building, technology transfer, full deployment of TRIPS flexibilities (including the waiver option);
- Providing for access and benefit sharing arrangements (through the BioHub) which are efficient and effective and fully aligned with the principles of the Nagoya Protocol of the CBD;
- Taking action around the commercial transformations driving the emergence of novel pathogens, including big farm high input agriculture, extractivism and deforestation;
- Understanding the cultural dynamics of particular populations in relation to trust in public health advice, including people facing conflict and displacement; people aggrieved by the deindustrialisation driven by the new global value chains; and people alienated by the commodification of human relationships, including the hubris of technological profit driven medicine;
- Acknowledging the continuing dynamics of colonialism as well as the structured inequalities of neoliberal globalisation which perpetuate the fiscal limitations of low and middle income countries;
- Affirming the importance of real health system strengthening (and not the deceptive promises of 'universal health coverage').

15.2 Standing Committee on Pandemic and Emergency Preparedness and Response

In focus

[EB150/17](#) contains a proposal for the creation of a Standing Committee on Pandemic and Emergency Preparedness and Response submitted by the Government of Austria.

The Board is invited to provide guidance and make recommendations regarding ongoing work on policy proposals on pandemic and emergency preparedness and response.

PHM Comment

This proposed standing committee could strengthen WHO's effectiveness in emergency preparedness and response but this is not guaranteed. It could also prove to be a big mistake.

The best guarantee of a wise decision would be a careful and inclusive discussion with consideration of a range of possible scenarios.

It is surprising that this proposal is brought to the EB in Jan 2022 while the member state working group on emergency preparedness and response is developing a more comprehensive package of proposals through a structured and deliberative methodology (see Agenda items 3 and 15.1).

PHM urges the Board to refer this proposal to the WGPR asking them to consider it in the context of their wider program of work.

15.3 WHO's work in health emergencies

In focus

[EB150/18](#) is provided pursuant to requests in resolution EBSS3.R1 (2015), decision WHA68(10) (2015) and resolution WHA73.8 (2020). It includes information on all WHO Grade 3 emergencies, the United Nations Inter-Agency Standing Committee Level 3 emergencies, and public health emergencies of international concern that required a response by WHO in 2021 (up to 30 September) at global, regional and country levels.

It also describes the response to the request in resolution [WHA73.8](#) in respect of the Surveillance System for Attacks on Health Care in complex humanitarian emergencies.

The Board will be invited to note the report. In particular the Board is invited to provide further guidance on

- how the Secretariat can further support Member States' access to COVID-19 tools, and ensure achievement of the WHO's strategy to achieve global COVID-19 vaccination by mid-2022 and its plan to vaccinate 70% of the population of all countries against COVID-19 by that date; and
- how the Secretariat can support Member States by ensuring that access to essential health services is prioritized and ensured in a context of ever-increasing need precipitated by the climate crisis, conflict, and COVID-19.

Background

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

PHM Comment

WHO's Emergency Program is carrying a huge workload and performing effectively.

Why did Europe and the US oppose the creation of a proper integrated-across-all-levels Emergency Program (including the Contingency Fund) for so long? Why did it take until the Ebola Disaster to persuade them of the need for a strong well organised whole of organisation emergency capacity?

Because they are so determined to constrain the capacity and reach of member state governed multilateral organisations. Why? Because developing countries have a voice in multilateral intergovernmental forums but transnational capital stands on the outside. As compared with the multistakeholder partnership which excludes most of the member states but makes space for the private sector.

WHO must also attend to the root causes of health emergencies

- poverty and displacement as root causes of many emergency situations and the role of transnational globalised capitalism in the shrinking of decent jobs and the widening of economic inequalities;
- mining, big farms and big dams generating and disseminating zoonotic pandemics;
- drought associated with climate change in driving migration and displacement and associated emergencies;
- conflict as a root cause of emergencies including conflict sponsored by the Great Powers and equipped by their arms manufacturers.

WHO needs to do a root cause analysis of the emergency situations it faces and document the politics of the humanitarian emergencies which it is called upon to address.

15.4 Influenza preparedness

In focus

[EB150/19](#) describes progress in strengthening influenza preparedness, notably in implementing the actions requested in decision [WHA73\(14\)](#).

The report also highlights the ways in which the capacities and systems developed for influenza preparedness have supported the coronavirus disease (COVID-19) pandemic response.

The secretariat invites the Board to focus on:

- the proposed expansion of the Global Influenza Surveillance and Response System to include other respiratory viruses with epidemic and pandemic potential; and
- guidance for further sensitizing Member States to the importance of timely influenza virus sharing.

Background

Op para 2(a). Pandemic influenza preparedness and seasonal influenza vaccination

Decision A73(14) asked the Secretariat to provide support to countries. The report provided in EB150/19 indicates that the Secretariat has provided a range of relevant resources.

However, the [survey of member states](#) conducted in 2019 had a disappointing response rate (54%) and revealed that many of the respondent countries were unprepared for a pandemic: some did not have a plan (38% of AFR respondents); in many cases the plan was not publicly available (46% of respondents who did have a plan).

Op para 2(b). Seasonal influenza preparedness

Decision A73(14) asked the Secretariat to promote timely access to, and distribution of, quality, safe, effective and affordable seasonal influenza vaccines, diagnostics, and treatments. The report provided in EB150/19 confirms that resources made available by the Secretariat do promote such availability.

The report comments that global influenza transmission has been at historic lows during the Covid pandemic and promises a more thorough analysis in due course.

Op para 2(c). Pandemic Influenza Preparedness (PIP) Framework

Decision A73(14) asked the Secretariat to promote and uphold the PIP Framework and to encourage viral sharing and benefit sharing.

EB150/19 reports on the collection and distribution of partnership contributions, on the conclusion of Standard Material Transfer Agreements 2 (SMTA2s) with vaccine manufacturers, and on the use of partnership contributions to strengthen country preparedness.

Capacity building using partnership contribution funds appears to have contributed to the Covid response in the areas of surveillance, regulatory capacity and public health knowledge.

Op para 2(d). Global Influenza Surveillance and Response System (GISRS)

Decision A73(14) asked the Secretariat to sustain and enhance influenza surveillance through WHO's Global Influenza Surveillance and Response System (GISRS).

EB150/19 reports on the growth of the GISRS and describes how the resources of GISRS were deployed during the Covid pandemic. The report flags the prospect of formally expanding the remit of the GISRS to serve as an integrated system for surveillance and monitoring of respiratory viruses with epidemic and pandemic potential and invites EB members to comment on the prospect of a GISRS+.

Under this heading EB150/19 also comments on instances where the sharing of influenza biological materials (seasonal and viruses with pandemic potential) within the GISRS may have been impacted by national regulatory measures, in some cases associated with the obligations of the Nagoya Protocol. The Secretariat refers to an earlier analysis provided in [EB146/18](#).

The Secretariat advises that it is engaging with Member States, GISRS members and the secretariat of the Convention on Biological Diversity to identify solutions and seek greater clarity on the sharing and use of seasonal influenza viruses and invites the EB to provide further guidance.

Op para 2(e). Synergies among influenza preparedness and response, International Health Regulations (2005) and immunization programmes

A73(14) asked the Secretariat to promote synergies between and among, efforts to implement: national plans for influenza preparedness and response; the International Health Regulations (2005); and immunization programmes. EB150/19 advises that the Global Influenza Strategy promotes such synergies.

The Secretariat reports on the development of a pandemic influenza vaccine response operational plan and advises that it is working to strengthen the policy basis for declaring an influenza pandemic.

Op para 2(f): Global influenza vaccine production capacity, supply chains and distribution networks

A73(14) asks the Secretariat to consult Member States and relevant stakeholders, including manufacturers, to identify gaps in, and priorities for, affordable, scalable, and sustainable global influenza vaccine production capacity, supply chains, and distribution networks.

EB150/19 refers to the results of a [2019 survey](#) which, inter alia, concluded that “challenges remain regarding maintenance of capacity and equitable distribution.” The report of the survey noted that most vaccine production capacity is based in HICs and concluded that continued efforts are needed to ensure the sustainability of production and to conduct research for vaccines that are faster to produce and more broadly protective taking into account lessons learned from COVID-19 vaccine development.

Further resources

See [Tracker links to previous discussions](#) of influenza preparedness, previously referred to as PIP.

See WHO topic pages on [Seasonal Influenza](#) and [Avian and other zoonotic influenza](#)

See home page for [WHO's Global influenza program](#)

PHM Comment

PHM has repeatedly insisted that the principles of access and benefit sharing as provided for in the Nagoya Protocol (and implemented under the PIP Framework), must be observed in the transfer of biological material and sequence data. (See PHM comment on [Item 15.3 at EB146](#) and on [Item 12.1 at WHA72](#).)

PHM highlights the need to expand public sector vaccine production capacity in the global South (including for seasonal and pandemic influenza). PHM urges the countries of the global South to invest in public sector innovation capability at the national or regional levels in relation to vaccine production.

15.5 Global Health for Peace Initiative

In focus

At the recommendation of the Officers of the Executive Board in 2021,¹ the Director-General submits [EB150/20](#) on the Global Health for Peace Initiative, which seeks to position the health sector as a contributor to peace and social cohesion by mainstreaming conflict sensitivity and peace responsiveness into WHO's programmes (contributing to the 'peace dividend'). The report outlines the work of the Initiative, its achievements and the proposed ways forward. The Board is invited to take note of the report and to provide guidance as set out in the document.

Background

For detailed presentation of H4P initiative see [Health and peace initiative](#). Geneva: World Health Organization; 2020 (Note the language: 'mainstreaming' (or 'programming') 'conflict sensitivity', and 'peace responsiveness'. Note the 'two level theory of change')

See also UNGA (2015) [Report of the High-level Independent Panel on Peace Operations on uniting our strengths for peace: politics, partnership and people](#) (A/70/95, from page 9)

See also the [UN Women Peace and security page](#). Note lack of reference to UN Women in WHO's current H4P docs.

See discussion of health and peace at [WHA34](#) (1981)

See WHO (1996) [Consultation on Health as a Bridge for Peace](#) (WHO/HPD/96.7)

[Garber \(2002\) Health as a Bridge for Peace: Theory, Practice and Prognosis — Reflections of a Practitioner](#)

[Wiist, W. H., Barker, K., Arya, N., et al \(2014\)](#). The role of public health in the prevention of war: Rationale and competencies. *American Journal of Public Health*, 104(6), e34-47.

PHM Comment

Conflict can have terrible consequences for health. Some of the most difficult challenges WHO faces arise in the context of conflict. These include instances of attacks on health workers. The WHO's Global Health for Peace Initiative's focus on mainstreaming conflict sensitivity and peace responsiveness into the strategy and programs of WHO and its many collaborators is therefore very welcome.

As an intergovernmental forum WHO has limited policy space where its member states are directly involved in conflict (overt and covert). However, as part of the UN system WHO is expected to contribute as part of a multi-sectoral approach to conflict response and peace-

making. This can be challenging when UN involvement, including UN authorized sanctions, intensify the harm caused by the conflict.

The Health and Peace Initiative document, published November 2020 has modest aims and it offers interesting possibilities for advancing both peace and healthcare in conflict zones. One of the main approaches it moots – its first theory of change- is moving from working in conflicts to working on conflicts through what it calls peace-responsive programming, and to do this while working across UN agencies and across WHO. Its second level theory of change talks of improving citizen-state cohesion, cross-line collaboration and the promotion of health and well-being and dialogue.

The Report on this agenda by the DG (EB 150/20) indicates that this agenda is in a very early stage of roll out and is struggling to establish this program. The current operational plan, built around six work-streams is too broad and generic and requires greater clarity on its deliverables and priorities.

PHM is of the view that this is a most important initiative and must be strengthened. We would call for strengthening and making it part of a comprehensive framework for WHO's role in war, occupation and conflict situations and with displaced populations. We call therefore for the following urgent measures to strengthen the Report and Action Plan through the following measures:

1. Evidence generation through research and analysis is a welcome proposed workstream; documenting, reporting and investigating the impact of war, armed conflicts and communal riots on health should be the evidence that drives change.. The documentation and evidence so generated must be presented in an annual report. Since the definition of conflict may vary, the H&PI must build an agreement on some common indicators of a conflict situation and then map these. This report could become a powerful tool for the H&PI to achieve its objectives. The strategy should also include mapping, even registration where feasible, of all non-combatant civil society organization involved in peace, humanitarian and health work as well as everyone in medical roles.
2. While reporting on the impact of armed conflict, special attention should be made to the plight of women, young girls and children who are often the worst sufferers of the conflict- being subject to physical and sexual violence, being denied basic amenities including food, and often being trafficked with impunity. Ethnic and racial discrimination, migration and displacement, while problems in their own right, add to the problems of women, young children and all marginalized sections. The report needs to acknowledge this problem and propose special efforts to address these issues. The report must ensure the Adoption and implementation of UNSCR 1325 and Subsequent Resolutions Adoption of UNSCR 1325 and Subsequent Resolutions and the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) General Recommendation 30 by the member states. No post-conflict or peacebuilding effort can be successful until Countries ensure that measures are taken, and systems are put in place, for victims of rape and other gender-based violence to testify and seek justice for the crime perpetrated against them.

3. Focus on Attacks on health workers and civil society organizations working on health: As part of its evidence-based approach the Global Health for Peace Initiative makes recording and reporting on the alarming number of attacks on health workers and their resources, including ambulances, a priority. These attacks need to be mainstreamed into conflict analysis and given priority as they undermine fundamental rights, international humanitarian law, and deny potential peace dividends. Such attacks deny access to healthcare, especially for populations made vulnerable by insecurity. All actions that deny or unnecessarily delay access to healthcare need to be recorded and reported on. Many of these are due to check-points and excessive bureaucracy, but all of these negatively affect the social cohesion that is a key aim of the Global Health for Peace Initiative. If health workers are prevented from carrying out their work through arbitrary detention or a denial of their rights this is also an attack on, and subsequent denial of, healthcare. If the link between health, social cohesion and peace is to be operationalized in situations of protracted conflict and insecurity, it is essential that any acts that threaten social cohesion and access to healthcare be called out.
4. In this context PHM draws attention to the outrageous illegal detention of Ms Shatha Odeh, a member of the PHM General Council and Director, of HWC a leading health CSO working in the occupied territories of Palestine by Israeli forces. She is being held along with a number of other health and human rights activists and the health relief organizations they are part of have been illegalized. This must be taken up as a test case and the WHO must re-double its efforts to secure their release and restore the work of their organizations. The annual reports provided to the WHA about the health circumstances in Occupied Palestine illustrate the political impact of speaking truth to power, but they also illustrate the limits on WHO reach when global superpowers are involved.
5. The Report emphasizes conflict analysis and the need to understand the specific nature of individual conflicts in order to promote peace. This is welcome. Conflict analysis needs to shed light on the multiple roots and drivers of aggression. These could lie in vertical or horizontal inequalities, the power dynamics of oppression, the remnants of a colonial past, or a neo-colonial present, as well as the more commonly cited ethnic divides and resource accumulation motives. Being able to demonstrate the present-day consequences for the health of these drivers puts WHO in a unique position to draw in collaborative partners to address them.
6. The Report makes no mention of the large scale attacks and displacements not only of Rohingyas, but other tribes also in Myanmar. It does not mention the situation in Ethiopia, Eritrea, South Sudan and Somalia.
7. In the section on partnerships, the importance of partnerships with civil society organizations like ICRC, MSF, MMI and even with PHM should be emphasized. This agenda cannot be taken forward without their engagement. They would also bring considerable understanding and experience to the WHO agencies involved in this work.

8. Global Health for Peace Initiative documents do not mention economic sanctions, the use of which has increased dramatically in recent decades. The damaging consequences of blanket economic sanctions for health are well known. Today's sanctions are often presented as 'smart' or 'targeted' against particular individuals, but evidence is accumulating that they damage the health of the vulnerable in the general population of the sanctioned country. WHO has a key role to play in recording and reporting these health consequences and bringing them to the attention of sanction-using countries through the appropriate UN mechanisms, and to the relevant UN bodies if the sanctions are UN-approved.
9. There is a need to intensify the dissemination of the Health and Peace Initiative Document and ask all regional WHO's to engage with this initiative in their region. There is also a need to intensify capacity building within the regional WHO's in this regard.
10. Country level health interventions require to be attempted in all conflict related displacements. But parallel to the operational team providing or facilitating healthcare an H&PI team should be mandated who would be constantly engaging the political leadership in health diplomacy, and facilitating societal and community level interactions.

In conclusion, while the PHM welcomes this initiative, the report gives the impression that it is more of a symbolic intervention and expression of intent, rather than an action plan, designed to make an impact. There is an urgent need to urgently strengthen this initiative.

16.1 Poliomyelitis eradication

In focus

[EB150/21](#) provides an update on work towards Goals 1 and 2 of the [Polio Eradication Strategy 2022–2026](#), notably on: interrupting all poliovirus transmission in countries where the virus is endemic, and stopping transmission of circulating vaccine-derived poliovirus and preventing outbreaks in non-endemic countries; the ongoing impact of the COVID-19 pandemic on the global polio eradication effort; and, the current financing situation at the end of 2021. The Board is invited to note the report.

Background

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

See [Polio Eradication Strategy 2022–2026](#) including Table 1. [Key strategic risks](#)

See [The World is Waiting, 19th report of the GPEI Independent Monitoring Board](#) (Dec 2020). Powerful critique of the GPEI, including for its technocratic approach and refusal to move towards integration.

See [Technical Guidance \(2020\)](#) on the use of Novel Oral Polio Vaccine Type 2 (nOPV2) for circulating vaccine-derived poliovirus Type 2 (cVDPV2)

PHM Comment

See [PHM comment](#) on this item at EB148

Polio is a dreadful disease. But, the commitment to eradication rather than elimination or control has come at a huge price. And the last mile is proving to be the most expensive, including in the lives of health workers.

Need to consider news of achievement with caution

The information that there has been a 98% decline in wild virus circulation and a 70% decline in vaccine derived poliomyelitis, while welcome, should come along with a caution that in the previous year systems of disease surveillance and routine polio services were disrupted by the pandemic- and therefore the decline could be the result of poor capture of information.

The main hot-spot for wild virus circulation is Afghanistan and Pakistan, where both COVID and war have led to considerable disruptions and almost a collapse of health systems in Afghanistan (see [map from TIMB4](#)). The introduction of novel OPV could have made a difference, but the introduction is too recent and relatively limited. It is not clear that the improvements relate to the introduction of the nOPV2.

The circulation of vaccine derived polio across Africa as well as in Afghanistan, Pakistan and Yemen, has also been exacerbated by conflict and drought.

Though the absolute number of cvDPVs have declined in 2021, many countries where cVDPVs were not detected in the past have started showing the presence of cVDPV, and this includes areas, and many of them in Western Africa. see <https://polioeradication.org/wp-content/uploads/2022/01/weekly-polio-analyses-cVDPV-20220104.pdf> . Increasing the capacity for environmental surveillance in these countries by including more sites can help identify pockets of circulation. The strengthening of environmental surveillance often translates into strengthening of laboratory surveillance in general.

The worsening of social determinants

This has also been a period where there is a sharp exacerbation of all the social determinants of polio spread. Most important of these is the expensive US war on Afghanistan, which despite costing hundreds of billions of dollars has led to a collapse of the then ruling regime and greater difficulties in polio eradication. And the US and its allies are still withholding access to financial assets which are the property of the government of Afghanistan.

War, civil strife and displacement are the most common determinant associated with all endemic countries of the Eastern Mediterranean Region added to this list: Syria, Iraq, Yemen, Libya, Somalia.

Virtually all of the polio priority countries are facing conflict, war, external destabilisation; and all are also facing problems of drought, poverty, poor access to safe drinking water and sanitation, unemployment and fragile health systems. There is a paradox here. On the one hand, disease eradication through a dedicated vertical program promised the rich countries that they could be protected from polio without regard to economic development, climate change, urban infrastructure or comprehensive primary health care in polio endemic countries. However, in reality, war and conflict has proven to remain a major barrier to immunisation; and lack of attention to sanitation and clean drinking water facilitates continuing transmission; and routine immunisation the insistence on a single insulated program for polio eradication sabotaging routine immunization earlier, and now Covid 19 immunization, undermining polio immunization. All of this has contributed to the emergence of circulating vaccine derived polio virus, as a bigger problem than wild polio virus, and calling for expenditure on many new oral vaccines even when the world is at the cusp of eradication.

Yet the Polio Eradication Resolution remains largely oblivious to the social determinants of the polio pandemic. We call on WHO and Member States to emphasize

- a) Need for greater action on prevention of all water-borne disease, by improving access to safe water and sanitation, especially in areas of displaced population.
- b) Need for greater attention to primary healthcare with adequate staff so as to maintain polio immunization plus routine immunization services plus the additional burden of Covid 19 vaccination that has largely devolved to polio workers in many countries

- c) Need for early and just resolution of conflicts and ensuring essential human rights including access to health services in conflict areas and in displaced populations.
- d) Measures for better surveillance and primary health care in areas of conflicts and displaced populations.

See [Annex E](#) of the Polio Eradication Strategy for a useful overview of the range of risks facing the achievement of eradication.

Governance Issues

Three years after the last case of polio caused by wPV, the world will be declared polio-free and the GPEI will close. However, vaccine derived polio virus will continue to circulate and leave paralysed children in its wake. It appears that as an organisation, the GPEI has been increasingly dysfunctional in recent years, riven by debates over 'integration' (of polio into routine immunisation) or continuing the singular vertical program and by turf warfare between different tribes within the Initiative. See the 2020 report of the GPEI Independent Monitoring Board, especially [Conclusions from page 57](#). See also [Annex H](#) of the Polio Eradication Strategy which summarises the findings of the 2020 Management Review, some of which are quite worrying.

Instead of closing down GPEI after the last case of WPV, its governance problems should be addressed and the institution re-positioned to support the strengthening of Routine Immunization. If any technical body, or institution simply ceases to function as and when we eradicate all forms of Poliomyelitis, the meaning of transition of knowledge and resources is lost.

Community Engagement and Trust

The intense community opposition to the polio teams in some countries suggests serious failures of strategy and operations (not just because of military spies being hosted in polio teams). The world is now also seeing different forms of stigma and denial with respect to the covid pandemic. One form that it takes is vaccine hesitancy. Vaccine hesitancy is highest where there is little trust between communities and the government. In some countries misinformation from right-wing ideological or communal elements leads to this. In most countries it is authoritarian states imposing policies without consultation and dialogue that drives this. Pre-existing stigma compounds new stigma. Addressing these issues through much greater community engagement and role should be a part of this strategy.

Vaccine Supplies: Old and New

[Batson et al. \(Nov 2021\)](#) comment that polio immunisation will be needed for many more years, both to prevent possible outbreaks of cVDPV and because polioviruses will persist in vitro for many years.

The [Polio Eradication Strategy 2022-2026](#) highlights (i) the need for an affordable supply of inactivated polio vaccines for Gavi and the LMIC market and (ii) the limited pool of suppliers of oral polio vaccines and the attrition of suppliers from the market and proposes to 'work with

UNICEF, vaccine manufacturers, containment and the nOPV2 WG to bring new suppliers to the market'.

The Polio Eradication Strategy 2022-2026 also highlights the need for extensive research and development but does not indicate how such research is being encouraged/funded nor the role of IPRs in pricing and ongoing vaccine access.

The report indicates that 100 m people were covered with nOPV2, but does not tell us the total required coverage, or even whether this coverage is from the most-at-risk West Africa and EMRO region countries. Increasing access to nOPV2, requires the strategy to address its manufacture and pricing.

Similarly, the report makes no mention of IPV availability, the extent of coverage with IPV, the financial burden this is imposing on stressed public systems and the efforts taken to assist governments in this regard or efforts taken to prevent monopoly and encourage more domestic manufacture. . Yet there is a tacit assumption that the exit strategy for current polio eradication efforts includes an indefinitely long duration maintenance of IPV as part of routine immunization systems.

In conclusion, nOPV supplies need to be ramped up to control outbreaks and with the discussion on cessation of Oral Polio Vaccine starting, the production of Injectable Polio Vaccine (IPV) needs to reach an all time high. We therefore demand for faster technology transfer for manufacture of all novel vaccines and IPV across all regions of the world and any country which is ready to undertake this. This is to avoid the repetition of inequity as was seen in access of CoVID-19 Vaccine especially in African Nations due to TRIPS, leading to dangerous aftermath of Virus mutation and emergence of Variants of Concern

16.2 Polio transition planning and polio post-certification

In focus

[EB150/22](#) provides a status update on the implementation of WHO's Strategic Action Plan on Polio Transition for the period 2019–2023 ([A71/9](#)), with a focus on progress and challenges at the country level. The Board is invited to note the report and provide guidance on:

- (a) accelerating the implementation of country plans in the context of COVID-19, ensuring the financial sustainability of transitioned functions; and
- (b) mitigating programmatic risks and recognizing opportunities in countries that are transitioning out of support from the Global Polio Eradication Initiative.

See [Figure on p6](#) of the Polio Transition Plan for a useful summary. See also [Table 4](#).

Background

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

See [4th Transition Independent Monitoring Board report \(TIMB4\)](#)

On the issue of Risks see [Polio Eradication Strategy - Annex E](#). See also [paras 50-57 of A71/9](#)

PHM Comment

See [PHM comment](#) on this item at EB148.

Three years after the last case of polio caused by wild polio virus, the world will be declared polio-free. However, polio immunisation will be needed for many more years, both to prevent possible outbreaks of circulating vaccine derived polio virus (cVDPV) and because polioviruses will persist in vitro for many years ([Batson et al, Nov 2021](#)).

The 'polio transition' refers to the hoped-for transfer of GPEI funded polio teams into national immunisation programs (or into WHO country programs) as GPEI funding dries up.

However, the polio transition is largely unfunded. Priority countries are facing precipitate reductions in GPEI funding which, particularly in the time of Covid (and in the face of ongoing conflict in many cases), they are unable to replace from domestic resources. If the transition is not fully funded, as the funding for polio teams disappears, those countries will lose highly trained personnel and systems.

The essential goals of the GPEI were directed to global health security; the safety of children around the world. However, the 10 polio priority countries are now being asked to replace the

declining GPEI funding from domestic resources and to continue to 'Sustain essential polio functions' but based largely on domestic funds mobilisation; still in the interests of global health security. These are poor countries, often suffering ongoing conflict and disruption, in many cases initiated and stoked by the rich countries (eg Afghanistan, Yemen).

[A71/9](#) (2018) noted (para 54) that the Secretariat was proposing a contingency fund to supplement domestic resources for the transition. This reference has disappeared from EB150/22 and is not mentioned in TIMB4.

One option for preserving the polio assets post GPEI, if domestic funding is not forthcoming, is for WHO to absorb them into its core establishment. [TIMB4\(p26\)](#) comments that:

Whilst most discussion on integration has focused on bringing together the polio and essential immunisation programmes, recent WHO polio transition work has also promoted the wider adoption of "public health teams". This approach will install within WHO country offices single teams with accountability for the combined functions of polio, disease surveillance, outbreak preparedness, detection and response, and essential immunisation. It is already a form of integration operational in some countries.

'Integration' should be a lot more than just integrating polio immunisation into routine immunisation. The polio transition provides an opportunity for a new push for health system reform based on comprehensive primary health care; the integration of local public health within comprehensive primary health care systems.

One specific systems component that was part of polio eradication but now requires strengthening for an overall health systems approach is the strengthening of diagnostic and laboratory networks in countries and its capacity for environmental surveillance for routine services as well as additional resilience required during epidemics. Genome sequencing, tacking familial lineage and monitoring for epidemic forecasting are also important.

Another specific area of integration is the multi-tasking of cadre of frontline workers who were involved in the polio eradication campaign. In 2020, in most countries, polio trained staff were directed towards COVID-19 surveillance and control measures. In 2021, the staff were diverted for COVID-19 vaccination and mobilization. This demonstrates the utility of these frontline in going beyond Polio eradication. Improving the working conditions, increasing their pay and strengthening this cadre is absolutely necessary not only for Polio eradication, but as part of building a surge capacity that reduces the vulnerability to any health disasters.

leads to skill upgradation and proves their tenacity and utility in Health System building for UHC. In every country the field staff engaged in Polio Eradication strategy could be tailored to take up other useful activities for system strengthening. Donor agencies could be requested for supporting a bridging programme to the State health sstem.

In India for example, a huge army of around 900,000 women, part time "voluntary" workers named ASHAs (*"Voluntary" is a highly exploitative arrangement to overcome requirements under the prevailing Labor laws*) were the back bone of entire surveillance activity in the community, contact tracing, getting suspects tested, quarantine of the family members and

isolation of clinically asymptomatic positives and reverse quarantine of the vulnerable and elderly during the Pandemic. If ASHAs were inevitable as intermediary between the health officials and Community, accept it and pay them right wages. Similarly, around 275,000 Contractual workers, Consultants and Technical hands are employed under National Health Mission, who are essential to run the project activities adding value to the program implementation. They are the corner stone for transforming Health services as a Mission instead of a departmental activity.

However, while WHO is obliged by its donors to pursue the deceptive promises of 'universal health coverage', this is unlikely. UHC as it is being promoted is about creating a publicly funded minimal safety net, based on a 'package of essential services' to be delivered through a marketised, increasingly privatised health system. 'Beyond the package' services would be supported by private health insurance and delivered through privatised providers. This is essentially the model that the World Bank has been marketing since 1993.

The full introduction of inactivated polio vaccine (IPV) into routine immunisation is critical for continuing to reduce the risk of outbreaks. Serious supply challenges in relation to IPV production. Causes of IPV shortages are not discussed in EB150/22.

[A71/9](#) suggests that polio resources post GPEI will stay in immunisation, surveillance and emergency response. See comments of [TIMB4](#) regarding 'integration'.

The polio transition raises issues of critical importance to the polio endemic countries and to the global South more generally. These range from the cost burden of the transition, the scope of 'integration', the conception of the GPEI as a singular vertical silo directed to the safety of the rich world, while the global governors perpetuate poverty, unemployment, global warming, and conflict.

It is of critical importance that civil society in the polio endemic countries is involved in debating the future of polio transition and the wider political and economic context.

17. Maternal, infant and young child nutrition

In focus

Following the request in decision [WHA73\(26\)](#) (2020), the Director-General submits [EB150/23](#) which reports

1. on progress regarding the comprehensive implementation plan on maternal, infant and young child nutrition,
2. on the progress in implementing the International Code of Marketing of Breast-milk Substitutes and
3. the continued inappropriate promotion of foods for infants and young children.

[EB150/23](#) also includes as an annex a report on the scope and impact of digital marketing strategies for the promotion of breast-milk substitutes.

The Board is invited to note the report and its annex and to consider a draft decision that recommends that the Seventy-fifth World Health Assembly request guidance for Member States on regulatory measures aimed at restricting the digital marketing of breast-milk substitutes.

Background

[Tracker links](#) to previous discussions of MIYCN and the Code on the Marketing of Breast-milk Supplements.

PHM Comment

The comprehensive implementation plan on maternal, infant and young child nutrition

The **global targets** for stunting, maternal anaemia, low birth weight, and wasting are not being met. Some progress is reported regarding exclusive breastfeeding.

EB150/23 reports that there has been a lot of talk about **food systems** and nutrition (FAO's Committee on Food Security's Voluntary Guidelines on Food Systems, UN Food Summit, G20, UN Nutrition, etc and the continuing critiques from public interest civil society organisations). However, there is no progress towards the global targets!

Apart from some guarded talk from G20 foreign ministers about "strengthening local diversified value chains for safe fresh and nutritious food" the established players are refusing to address neoliberal globalisation (including the disciplines of the WTO Agreement on Agriculture) as a major driver of global malnutrition.

Blinded by the promises of a never ending flow of technical fixes (including the Gates funded AGRA), the large scale models of industrial farming of North America and Europe are being

imposed upon L&MICs without regard to small farmers' livelihoods, agroecological considerations or long term ecological consequences.

Notwithstanding the reference to global warming there is no reference in EB150/23 to the gross overconsumption of meat in the global North and its implications for the health of those populations and of the planet.

EB150/23 reports that coverage of essential nutrition actions within **primary health care** delivery is low in most countries and lags far behind the coverage of health services not related to nutrition. The Secretariat announces new opportunities for preventing and treating malnutrition arising from global momentum towards "universal health coverage".

"Universal health coverage" is code for a minimal publicly funded safety net based on defined benefit packages with services "purchased" from public, private and voluntary service providers in a marketised health care system. Services 'beyond the package' will be delivered in a privatised system funded through health insurance. This commodification, privatisation and fragmentation of service programs is quite incompatible with comprehensive primary health care.

This is a system which the World Bank has been advocating since 1993 and Rockefeller has been driving since 2008. Until Drs Chan and Tedros WHO had resisted but now, in a spectacular display of cognitive dissonance (driven by WHO's donor dependence) WHO is promoting the WB/Rockefeller model.

Implementation of the International Code of Marketing of Breast-milk Substitutes

Notwithstanding 40 years since the Code was adopted EB150/23 reports that the marketing of formula milk is pervasive in most countries and that health systems are major conduits for the promotion of breast-milk substitutes. The report provided in the Annex to EB150/23 reveals that the marketing of breast-milk substitutes through digital media is highly effective and increasingly the dominant mode of promotion.

[Victora, Bahl, Barros et al \(2016\)](#) estimate that the scaling up of breastfeeding to near universal levels could prevent 823,000 child deaths and 20,000 breast cancer deaths every year

It appears that (largely male) politicians in too many countries are privileging the dairy industry and powdered milk producers over infant nutrition and community health. Health service managers and senior clinicians are also turning a blind eye to the promotion of breast-milk substitutes in their facilities. The Baby-friendly Hospitals Initiative is in shambles.

These are major challenges for public health.

Inappropriate promotion of foods for infants and young children

EB150/23 reports on some work regarding the marketing of commercial complementary foods for infants under 6 months, including the marketing of foods with free sugars, and inadequate

labelling regarding sugars and salt. The work reported in EB150/23 is appreciated but it is far less than would be needed to implement [WHA69.9](#) (2016).

See the [extended IBFAN commentary](#) on the Codex Nutrition Meeting of 19-25 Nov and 1 Dec 2021. IBFAN comments on conflict of interest within FAO, the conflicts of the regulation of 'sweetness', flavoring of drinks marketed for infants, ready to use therapeutic foods

WHO's work program in this area needs to be scaled up dramatically.

Draft decision

PHM urges member states to support the proposed decision.

However, much more needs to be done, in particular, around the political economy of food systems, the deceptions regarding nutrition embedded in the false promises of UHC, the need to curb and redistribute meat consumption, the political economy of the opposition to the Code, and the regulation of content, labelling and marketing of foods marketed as for infants and young children.

18. WHO's implementation framework for Billion 3 and Global Strategy for Food Safety

In focus

WHO's Implementation framework for Billion 3

[EB150/24](#)

Presents the six strategic objectives and reports on the achievements and challenges of ten cross cutting initiatives.

WHO global strategy for food safety

[EB150/25](#) - Draft WHO global strategy for food safety (here in full [Draft global strategy for food safety](#)) submitted for adoption in accordance with [WHA73.5](#): Strengthening efforts on food safety

See PHM comment below.

The sale of live wild animals in traditional food markets

[EB150/26](#) - Reducing public health risks associated with the sale of live wild animals of mammalian species in traditional food markets – infection prevention and control

EB150/26 provides useful background information. The Board is invited to adopt the draft decision at para 39 which requests the DG to update the interim guidance, to develop plans to support country implementation of interim guidance, and to report back.

PHM Comment

WHO global strategy for food safety

[EB150/25](#) - Summary of WHO global strategy for food safety, and here in full: [Draft global strategy for food safety](#)

[WHA73.5](#): Strengthening efforts on food safety

[Tracker links to previous discussions of food and food safety](#)

Myopic vision

The vision offered is *the prevention of food borne disease*. This vision requires the strengthening of food control systems (understood as the regulatory mechanisms, including food standards, surveillance and compliance).

However, food control systems are also intensely relevant to public health nutrition goals (including various forms of malnutrition and NCDs); to food systems and climate change (food miles, meat alternatives, food waste); microplastics and food packaging; and small farmers' livelihoods (facing competition from cheap imported highly processed energy dense packaged foods).

By restricting the *vision* to food borne disease, consideration of these other purposes of food systems control has been precluded.

The message to member states is, 'strengthen food control systems insofar as they are relevant to food safety but do not have regard to their other functions'.

Public health and trade facilitation

Strategic priority 5 is 'Promoting food safety as an essential component in domestic, regional and international food trade' and element (iii) of this priority is to 'Ensure that national food safety systems are aligned with the standards of the Codex Alimentarius Commission to protect public health and facilitate trade'.

The Codex Alimentarius is co-sponsored by WHO and FAO.

The Codex Alimentarius is a collection of internationally adopted food standards and related texts presented in a uniform manner. These food standards and related texts aim at protecting consumers' health and ensuring fair practices in the food trade. The publication of the Codex Alimentarius is intended to guide and promote the elaboration and establishment of definitions and requirements for foods to assist in their harmonization and in doing so to facilitate international trade.

The power to 'facilitate international trade' has been granted to the Codex by the World Trade Organisation and trade dispute tribunals. If a member state of the WTO is accused (under the Sanitary and Phytosanitary Agreement) of applied food standards which unduly restrict trade, their defense depends on whether the alleged trade restricting provisions are aligned with Codex standards. Similarly in investor state dispute litigation under other preferential trade agreements, the public health defense depends on food standards which are aligned with those of the Codex.

It is quite astonishing that an organisation co-sponsored by WHO and FAO should take upon itself the mandate of 'facilitating international trade'. Unfortunately the Codex is controlled by the food industry; the contributions of public interest civil society organisations are ignored. Democratising the Codex is a priority.

The proposition that more is better; that more international trade is somehow better for everyone is neoliberal ideology and not evidence-based (as promised under Strategic priority 3 of the new draft global strategy). There are many situations where more international trade is not better.

The expansion of international trade is highly problematic when transnational food companies dump cheap ultra-processed foods into developing country markets and bankrupt small farmers

(forcing urban migration) while driving the upswing in NCDs. Likewise when local food manufacturers are driven out of business by the importation of cheaper, globally sourced product, transported across much greater distances, the value of 'trade facilitation' must be questioned.

Harmonisation

The notion that globally uniform food standards are better than national or regional standards is also problematic, although clearly beneficial to transnational suppliers.

The science of food standards is strongly influenced by the circumstances of rich countries; this is where most of the scientists are based. So, if clean food is good, then cleaner food must be better. This approach suits the large transnational manufacturers who can afford state of the art manufacturing. However, the progressive ratcheting up of food standards (upward harmonisation) will progressively drive small local producers out of business.

However, in relation to standards directed to improving public health nutrition a contrary situation applies. If countries promulgate nutritionally directed standards, such as nutrient profiling, they risk being found in breach of their trade agreements because the Codex standards are so much less stringent.

PHM urges the EB to reject the draft global strategy and to ask the DG to try again. A new draft is needed, one in which the implications of climate change, public health nutrition, food security and food sovereignty and the environmental harm from microplastics are fully addressed.

19.3 Sustainable financing: report of the Working Group

In focus

The Working Group on Sustainable Financing (WGSF) was formed pursuant to decision [EB148\(12\)](#) (2021). Note that the decision provides that the WG “shall submit its final report with its recommendations and other findings” to EB150.

Likewise the [Annotated Agenda for EB150](#) anticipates that the Board will be presented with the final report of the WG including its findings and recommendations.

In fact, the WG has not finished its work. [EB150/30](#) conveys a report of its fifth meeting with two appendices:

- a contested set of draft recommendations, and
- a draft final report, prepared by the bureau of the WG, which was not considered during its fifth meeting.

EB150 invites the Board to note the report and provide further guidance. The EB (informed by the advice of the PBAC who will consider the report first) may choose to extend the life of the WG, perhaps with further guidance regarding the contested issues.

Background

Important background to the creation of the WG is included in [EB148/26](#).

It appears (from Appendix 1 to [EB150/30](#)) that the WG achieved consensus on:

- the unsustainability of the current funding model;
- the need for stronger MS oversight of planning, budgeting and reporting, in particular, through strengthening the role of the PBAC;
- the need for donors to move to fully unearmarked contributions in the financing of WHO’s base segment;
- exploration of a replenishment mechanism for financing the WHO budget;
- the establishment of a member state task group focused on strengthening the governance of WHO’s budget, planning and financing;
- increasing program support costs to full cost recovery.

The WG considered but did not achieve consensus on proposals to:

- progressively increase ACs to 50% of the base segment; and/or
- explore private sector sources of funding.

The draft final report, prepared by the Bureau of the WG, throws further light on its thinking. See in particular, the Chair's 'seven non-exhaustive main themes' emerging from the discussion, listed in para 21 of Appendix 2

The summary of regional committee feedback to the WG demonstrates wide support for fully flexible funding of the base segment, and widespread sympathy with the prospect of a staged increase in ACs to provide 50% of the base segment. However, there were several expressions of concern regarding the impact of the Covid pandemic on national capacity to increase their contributions to WHO.

See [Tracker links to previous discussions of WHO Financing](#). See in particular [EB148/26](#) which informed Decision [EB148\(12\)](#).

For the documents of the WG see its homepage ([WGSEF](#)).

For a summary of WG deliberations from its chair, Björn Kümmel, Germany, see [Elaine Ruth Fletcher \(09/12/2021\) WHO's Finance Structure is 'Fundamentally Rotten' – Reforms On Table Next Week Would Restore Responsibility to Member States](#)

PHM Comment

PHM urges the EB to extend the life of the WG and to urge it to pursue with redoubled efforts the fully flexible funding of the base segment including a phased increase in ACs to 100% of the base segment by 2029-30.

21.1 Strategies and plans scheduled to expire: the Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property

In focus

Paras 1-3 of EB150/36 provide a useful background regarding where this item has come from and the decisions facing the EB.

1. Following a two-year negotiation process, the Sixty-first World Health Assembly in May 2008 adopted in resolution [WHA61.21](#) the global strategy and plan of action on public health, innovation and intellectual property for the period 2008–2015. In the following year, the Health Assembly adopted resolution [WHA62.16](#) (2009), in which it finalized the list of stakeholders responsible for the implementation of each element and sub-element, established progress indicators for each element, and proposed time frames in which the specified actions should be accomplished.
2. Concerned about the pace of implementation, the Sixty-eighth World Health Assembly in 2015 decided in resolution [WHA68.18](#) to extend the time frame of the plan of action from 2015 until 2022 and to undertake an overall programme review [actually had been requested in OP6 of [WHA62.16](#)]. In 2017, the report of the review panel recommended a way forward, including details of what elements or actions should be added, enhanced or concluded in the next stage of implementation until 2022 [[Full report](#) and in summary at [A71/13](#)].

Note that [Rec 32 of the review panel](#) proposes that the Secretariat draws up a detailed implementation plan and establishes a mechanism to support implementation and monitoring of the global strategy and plan of action.

The report of the review panel was considered at EB142 in Jan 2018 where both [Europe](#) (represented by Malta) and the [US](#) alleged that certain of the recommendations of the review panel did not emanate from the original GSPOA. EB142 adopted decision [EB142\(4\)](#) which was adopted, as amended, by WHA71 (May 2018) as [WHA71\(9\)](#). See also [US comments at WHA71](#).

Speaking at EB142 [Brazil](#) noted that the review panel recommendations which were said to be not emanating from the GSPOA were recommendations 4, 27 & 28 all of which were directed at member states.

EB146 (Feb 2020) reviewed the implementation of the review panel recommendations and recommended a [draft decision](#) which was adopted by WHA73 as [WHA73\(11\)](#). This decision emphasises the obligations of member states regarding the review panel recommendations as elaborated in [WHA71\(9\)](#).

EB148 (Jan 2021) [noted](#) document [EB148/10](#) including the Secretariat's proposed Implementation Plan 2020-2022 "to guide further action on the prioritised recommendations of the Review Panel *addressed to the Secretariat*". To assess progress in implementation of the recommendations *addressed to Member States*, the Secretariat conducted a [questionnaire](#) to gather information from Member States and plans a follow up survey in 2022.

3. This report ([EB150/36](#)) responds to the request to the WHO Secretariat to draw up a detailed implementation plan and establish a mechanism to support implementation and monitoring of the global strategy and plan of action. Additionally, in 2020, in decision [WHA73\(15\)](#), on WHO reform: governance, the Health Assembly requested that the Director-General systematically include as substantive items on the provisional agendas of meetings of WHO's governing bodies any global strategies or action plans that are scheduled to expire within one year in order to allow Member States to consider whether the global strategies or action plans have fulfilled their mandates, should be extended and/or need to be adjusted; this is the case for the global strategy and plan of action on public health, innovation and intellectual property in 2022.

The Board is invited to note [EB150/36](#) and provide further guidance on the possibility of extending the time frame of the plan of action beyond 2022, taking stock of further discussions and actions that have taken place to implement the plan of action.

The Board is likely to agree on extending the time frame. What will be in contention will be the scope of the mandate that is authorised for the next stage.

Background

[Tracker links](#) to previous discussions of the GSPOA

[A chronology of WHO discussions of Intellectual property, innovation and public health](#)

To fully assess the progress report provided in [EB150/36](#) it is necessary to compare it with the [original GSPOA](#), the recommendations of the review panel ([A71/13](#)), and the implementation plan in [EB148/10](#). Also to recognise that [EB150/36](#) and [EB148/10](#) only deal with the prioritised recommendations addressed to the Secretariat.

PHM Comment

As provided for in decision [WHA73\(15\)](#), **the term of the GSPOA must be extended** (to at least 2030) because:

1. The WHO Secretariat still has much work to do to fully implement the recommendations of the review panel directed to the Secretariat as requested in para 3 of [WHA71\(9\)](#); and
2. The governing bodies have had no advice regarding the implementation by member states of paras 1 & 2 of WHA71(9) or paras 1, 2 & 3 of [WHA73\(11\)](#).

The WHO Secretariat still has much work to do to fully implement the recommendations of the review panel directed to the Secretariat

The following notes are structured under the headings used in [EB148/10](#), and [EB150/36](#). Keep both of these files open while reading the below commentary.

Prioritizing research and development needs (recs 2 & 3 of the review panel)

Rec 2 from the review panel asks for the development of a methodology for the prioritization of research and development needs. The implementation plan envisages focusing on malaria products and to seek the advice of the Expert Committee on Health Research and Development.

EB150/36 reports on the work of WHO's Global Observatory on Health Research and Development in R&D prioritisation in relation to malaria supported by the Global Malaria Program and with the advice of the Science Council.

Rec 3 of the review panel calls for advice from the Expert Committee on Health Research and Development regarding R&D prioritisation drawing on evidence assembled by the Global Observatory. The implementation plan promises to continue the work of the Observatory giving priority to priority pathogens, antibiotics, diagnostics for sepsis, and medical devices, and to seek legal advice regarding WHO's constitutional powers to undertake health research

EB150/36 reports on the work of the Observatory on R&D prioritisation; in 2021 the focus was on antibacterial products. A useful range of target product profiles (TPPs) and product profile characteristics (PPCs) is documented on the website.

The Observatory depends on a wide range of data collections and reports in its prioritisation work; many of these are somewhat divorced from lived experience on the clinical frontline and the context in which the products will be deployed. **There may be some scope for building closer relationships with clinical observatories on the ground as part of the prioritisation process.**

It is worth noting the [comment](#) on the Observatory website about public health oriented funders of global health who **have chosen to operate alternative approaches** to the development of TPPs rather than work with the WHO Observatory. This is unfortunate.

Good work is being done here; the critical question is **whether the funding for product development will be forthcoming.**

Promoting research and development (recs 5 & 7 of the review panel)

The implementation plan for Rec 5 from the review panel envisages building up the capacity and role of the Observatory and engaging with a diverse range of stakeholders to promote evidence-informed decisions in funding health research. Clearly the first aspect is progressing well but in relation to the second aspect EB150/36 mentions only the Special Program research project on Chagas disease, hookworm and other soil transmitted helminths.

There appears to be **scope for more active engagement with national and philanthropic research funders** to highlight the urgent research priorities. Perhaps after Covid.

Building and improving research capacity (recs 8, 9, 10 & 12 of the review panel)

The implementation plan for Rec 8 calls for tools and standards to strengthen national research capacity and for the development of international collaboration programs to support capacity development. **The omission of any reference** to such in EB150/36 suggests that not much progress has been made.

Rec 9 deals with strengthening regulatory capacity including in relation to clinical trials. The implementation plan lists a range of actions for the Secretariat directed to such regulatory capacity building. EB150/36 points to a number of such actions undertaken.

Rec 10 calls for a database regarding R&D training programs for developing countries. The implementation plan promises consultation regarding this database. **There is no reference to such a database** in EB150/36.

Rec 12 asks the Secretariat to support MSs in capacity building for policy, regulation and research in traditional medicine. The implementation plan lists a range of actions for the Secretariat in providing such support. EB150/36 lists a number of activities undertaken to fulfill such commitments.

Promoting transfer of technology (recs 13, 14 & 15 of the review panel)

Rec 13 of the review panel asks the Secretariat to identify mechanisms to increase health technology transfer. The implementation plan envisages a report, a conference, knowledge sharing, partnership building and the development of an action plan.

Rec 14 asks the WHO Secretariat to work with colleagues at the WTO on implementation of [Art 66.2](#) of the TRIPS agreement on technology transfer.

EB150/36 refers to the development of guidelines on technology transfer in pharmaceutical manufacturing and to joint webinars with UNCTAD on local vaccine production in the context of Covid. The Secretariat has held discussions regarding technology transfer with least developed members and promises a report. **However, Art 66.2 actually assigned primary responsibility for technology transfer to ‘developed country Members’**. Presumably the MS questionnaire referred to in para 3 of EB148/10 will assess their commitments in this respect.

Rec 15 envisages closer collaboration in the UN system around technology transfer. The implementation plan lists a range of actions that the Secretariat would take (a tool, meetings, a model action plan, conference etc).

Clearly Covid 19 interfered with these proposed actions. EB150/36 refers to WHO’s May 2020 Solidarity Call to Action and the Covid Technology Access Pool as initiatives directed to technology transfer in the context of Covid. These initiatives were widely disregarded by the

countries with advanced technologies and were treated with contempt by leading pharmaceutical manufacturers.

Managing intellectual property to contribute to innovation and public health (recs 16, 17 & 18 of the review panel)

Rec 16 of the review panel urged the Secretariat to advocate for national legislation to allow for the full deployment of all of the TRIPS flexibilities. The implementation plan committed the Secretariat to collecting IP related information including information from MSs about their national legislation. EB150/36 reports that the Secretariat is working with those of the WTO and WIPO to promote the full deployment of TRIPS flexibilities in national legislation.

The implementation plan envisages the Secretariat providing support to countries regarding the implementation of TRIPS flexibilities in domestic legislation. EB150/36 does not describe progress in this respect.

The implementation plan commits WHO to work with WIPO and WTO in preparing a report on national legislation and patenting guidelines includes the flexibilities provided in the TRIPS Agreement, in accordance with action [5.2\(a\) and \(b\)](#) of the GSPOA. (These deal with (a) the implementation of TRIPS flexibilities in domestic legislation, and (b) giving full consideration to public health when considering TRIPS plus provisions.) EB150/36 reports that the Secretariat is working on a report about the use of TRIPS flexibilities but provides no indication of what this will cover.

Rec 17 of the review panel report urged the development of user-friendly databases regarding patent status and license agreements. The implementation plan included such a commitment and EB150/36 reports that the Secretariat is working to encourage the development of user-friendly databases of patent status and licensing information for key health technologies. The Secretariat is also developing under C-TAP a global one-stop database providing access to information to promote sharing of Covid technologies and the scale up of manufacturing.

Rec 18 of the review panel calls for support to the Medicines Patent Pool and (perhaps) expansion of its portfolio. The implementation plan commits the Secretariat to exploring the further development of patent pools, the development of databases on health related patents, and the development of patent landscapes to promote further development of products and access to necessary health commodities. It appears from EB150/36 that some **limited** progress has been made here.

Improving delivery and access (recs 20-23 & 25-26 of the review panel)

Rec 20 concerns evidence based selection (as in essential lists) and health technology assessment. The implementation plan promises support for the management of health product supply and use. It promises operational research regarding the use of products and promises a report on bilateral and regional collaboration.

Rec 21 asks WHO to provide guidance regarding price transparency and the implementation of pricing and reimbursement policies. The implementation plan promises guidelines, manuals and the publication of pricing information.

Rec 22 looks towards mechanisms to monitor out-of-pocket expenditure on health products. The implementation plan promises a range of tools and guides.

Rec 23 deals with regulatory capacity building including regional harmonisation. The implementation plan promises a number of specific actions: convening, norms, training, technical assistance and monitoring.

Rec 25 looks towards more appropriate use of new and existing medicines and health products in national clinical practice. The implementation plan promises a number of relevant actions: manuals, guidance, training etc.

Rec 26 looks towards improved procurement and supply chain management at national and regional levels. The implementation plan promises a range of relevant actions: training, guidelines, technical assistance, etc.

EB150/36 describes a range of activities undertaken by the Secretariat in response to these needs. They show that excellent work is being done.

However, EB150/36 does not provide the grounds for considering what the Secretariat is doing against the breadth of problems globally which it is attempting to address.

The Secretariat has published good practice on product selection and technology assessment but EB150/36 is not able to contextualise efficacy and impact of this work against the extant needs.

Likewise guidance on pricing policies has been updated but what has been its efficacy and impact at the national level.

The Secretariat's work on regulatory capacity building and regional harmonisation is to be greatly appreciated. However, only 27% of WHO's member states are operating at maturity levels three or four.

Good work is reported on antibiotic use but what has been the impact in the clinic?

It is apparent that many excellent initiatives are being progressed but it seems likely that they will need substantive scaling up, as well as complementary work by national authorities, for their impact to be commensurate with the scale of the problems they are addressing.

Promoting sustainable financing mechanisms (rec 31 of the review panel)

Rec 31 (n increase and diversification of funding for product development partnerships) is essentially directed at member states although with Secretariat support. The implementation plan promises technical and political support for the Global Antibiotic R&D Partnership

A150/36 reports on the G-FINDER project which tracks and reports on member state funding of R&D for neglected diseases.

Monitoring and accountability (rec 32)

Rec 32 from the review panel called for a detailed implementation plan. This recommendation was met with the implementation plan which was submitted by the Secretariat in [EB148/10](#) which was [noted](#) by EB148 (in Jan 2021).

Recommendations of the review panel directed to member states (1, 4, 6, 11, 24, 27-30 & 33)

The recommendations of the review panel directed to member states (1, 4, 6, 11, 24, 27-30 & 33) are not encompassed by the implementation plan. See [A71/13](#) for a numbered summary of the recommendations.

[WHA71\(9\)](#) urges member states to:

- (1) to implement, as appropriate and taking into account national contexts, the recommendations of the review panel that are addressed to Member States and consistent with the global strategy and plan of action on public health, innovation and intellectual property;
- (2) to further discuss the recommendations of the review panel not emanating from the global strategy and plan of action on public health, innovation and intellectual property (which according to Brazil at EB142 are recs 4, 27 & 28).

These urgings were underlined in [WHA73\(11\)](#) which decided to:

- (1) to urge Member States to reinforce the implementation, as appropriate and taking into account national contexts, of the recommendations of the review panel that are addressed to Member States and consistent with the global strategy and plan of action on public health, innovation and intellectual property;
- (2) to reiterate the necessity for Member States to further discuss, in informal consultations to be convened by the Director-General in 2020, the recommendations of the review panel referred to in paragraph 2 of decision WHA71(9) (2018); and
- (3) to call on Member States to further discuss, in informal consultations to be convened by the Director-General in 2020, the recommendations of the review panel on promoting and monitoring transparency of medicines prices and actions to prevent shortages;

It appears that no progress has been reported to the governing bodies regarding the implementation of these urgings.

[EB150/36](#) advises that to assess progress in implementation of the recommendations *addressed to Member States*, the Secretariat conducted a [questionnaire](#) to gather information from Member States and plans a follow up survey in 2022.

PHM urges EB150 to mandate a mechanism to hold member states accountable for respecting decisions WHA71(9) and WHA73(11).

21.2 WHO reform: involvement of non-State actors in WHO's governing bodies

In focus

As requested by the Board in February 2021 at its 148th session, the Secretariat trialed virtual informal meetings with non-State actors in official relations, Member States and the Secretariat ahead of the Seventy-fourth World Health Assembly. It also trialed constituency statements for a limited number of agenda items at the Health Assembly. In [EB150/37](#) the DG reports to the Board on the feedback received on the trials and proposals for the way forward.

The Board is invited to note the report and consider a draft decision proposing continuation of the informal meetings annually before sessions of the Health Assembly, and for trialing constituency statements again during the Seventy-fifth World Health Assembly.

Background

[Tracker links to previous discussions of NSAs](#)

PHM Comment

Both the 'informal meeting' and the 'constituency statements' are strategies for achieving agenda control and preserving (the appearance of) member state sovereignty in WHO's governing bodies.

In another universe the effort which has gone into these 'reforms' might have been invested in building stronger partnerships with social movements working towards health equity globally, nationally, locally. Such partnerships could contribute significantly to democratising global health governance.

Consider the World Bank and USAID dominated push for 'universal health coverage' (code for privatised health care with a publicly funded minimal safety net). Rather than join the sloganeering around UHC, the Secretariat could share with grass roots health activists the politics behind the UHC slogan and the implications for quality, efficiency and equity of marketised health care.

Consider the wall of protection around extreme intellectual property rights thrown up by Europe and the US in the face of deliberate (and genocidal) restrictions on vaccine supply during the Covid-19 pandemic. Rather than bemoaning vaccine nationalism the Secretariat could be working with grass roots activists to demystify the political economy of transnational pharma and its protectors and challenge the forces behind the privatisation of knowledge and technology.

Consider the degree to which WHO has been forced through the freeze on ACs and tightly earmarked donor funding to cede increasing authority in global health to unaccountable private

donors and to multi-stakeholder public private partnerships - like the ACT Accelerator - where transnational business organisations replace member state sovereignty. Rather than pretending that it is not happening the Secretariat could be reaching out to social movements seeking allies in defending the integrity of the WHO.

21.3 Engagement with non-State actors

In focus

In accordance with resolution [WHA69.10](#) (2016) and the [Framework of Engagement with Non-State Actors](#) (subparagraph 68(a)), [EB150/38](#) provides the sixth annual report on WHO's implementation of the Framework. The Board is invited to note the report.

In line with the provisions of the [FENSA](#), the EB is mandated, through the PBAC, to consider applications for admittance of non-State actors into official relations and to review collaboration with one third of the non-State actors in official relations in order to decide whether to maintain, defer the review or discontinue their official relations. The Board is invited to note the report in [EB150/39](#) and to consider the draft decision at para 21 (with fin & admin implications in [EB150/39 Add.1](#)).

Background

FENSA

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

NSAs in Official Relations

See [Tracker links to previous discussions of NSAs in Official Relations](#)

PHM Comment

FENSA

The steps reported in EB150/38 being taken by regional committees to make provision for closer relations with non-state actors are appreciated.

However, there remains a stark disjunction between the care with which FENSA is being implemented and the parallel drive to transfer global health functions out of WHO to various multistakeholder partnerships (such as the ACT Accelerator) where philanthropic foundations (Gates, Wellcome) and business associations (IFPMA) play governing roles.

24 Report on meetings of expert committees and study groups: food contaminants, food additives and essential medicines

In focus

[EB150/48](#) reports on meetings of expert committees and study groups, including a summary of the recommendations contained in the reports of expert committees and observations on their significance for public health policies and implications for the Organization's programmes. The Board is invited to note the report.

[EB150/48 Add.1](#) provides details of both meetings and membership in respect of expert committees that met in 2021.

Background

[EB150/48](#) reports on meetings of:

- Joint FAO/WHO Expert Committee on Food Additives, evaluating certain food contaminants including the occurrence of and dietary exposure to ergot alkaloids as a food contaminant, the dietary exposure to cadmium from all food sources, the acceptability of one group of substances as previous cargoes and a revision of the specifications on steviol glycosides.
- Joint FAO/WHO Expert Committee on Food Additives evaluating certain food additives: benzoic acid, its salts and derivatives; collagenase from *Streptomyces violaceoruber* expressed in *S. violaceoruber*; β -glucanase from *Streptomyces violaceoruber* expressed in *S. violaceoruber*; phospholipase A2 from *Streptomyces violaceoruber* expressed in *S. violaceoruber*; riboflavin from *Ashbya gossypii*; and ribonuclease P from *Penicillium citrinum*
- Expert Committee on the Selection and Use of Essential Medicines, on the selection and use of essential medicines, recommended the addition of 20 new medicines to the WHO Model List of Essential Medicines and 17 to the WHO Model List of Essential Medicines for Children; 15 medicines or formulations recommended for deletion; a total of 25 applications, involving 28 medicines, proposing amendments to one or both of the Model Lists, not recommended.

PHM Comment

Essential medicines

PHM:

- Supports the Committee's recommendation that quality-assured similar biotherapeutic products (biosimilars) should be considered appropriate therapeutic alternatives to the originator medicines for the purpose of national selection and procurement.
- Endorses the Committee's concerns regarding prohibitively high prices (and specialized diagnostic requirements) having unsustainable impacts on health budgets. Underscores the Committee's call for global and national strategies and interventions aimed at reducing prices and facilitating affordability and access.
- Endorses the Committee's call for expansion of the WHO prequalification programme to include highly priced essential biological medicines, particularly in the areas of cancer and autoimmune diseases, with a view to improving access and affordability of such medicines in low- and middle-income countries.
- Supports the Committee's recommendation for a multidisciplinary expert working group to support the Committee in providing advice to WHO on policies and actions to make highly priced essential medicines more affordable and accessible.

The emergence of very expensive medicines for rare diseases underlines the importance of rigorous cost effectiveness studies using appropriate methodologies and undertaken at the national or regional levels having regard to country specific epidemiological and economic circumstances.

However, pharmacoeconomic evaluation is a double edged sword. In defining benefit packages for a safety net funding (as in WHO's "universal health coverage") it can be used to deny access to basic health care. However, in publicly funded single payer systems, cost effectiveness studies can be used to ensure the efficient use of limited resources.

Member states might choose to request a report on the use of pharmacoeconomics in medicines regulation and subsidisation and how it can be used to promote access to effective health care.