



Health for All Now!

People's Health Movement

Policy Briefs on Important Issues before WHA 71

Issued through the aegis of the People's Health Movement's
(www.phmovement.org) WHO Watch Programme

Refer to our detailed Commentary on the entire agenda of WHA 70 at
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11.1 Draft thirteenth general programme of work, 2019–2023

Summary

WHA 71 will adopt the General Program of Work 2019-2023, based on Documents A71/4, A71/4 Add.1, EB142/2018/REC/1, and resolution EB142.R2. For earlier comments on this agenda item, see [PHM statement](#) from 13th November 2017 and [MMI statement](#) from EB142.

GPW 13 provides a framework for the organisation's work in the next 5 years. It describes a number of areas which have been identified to be of strategic importance by the WHO secretariat and Member States. The new GPW, it is claimed, will strengthen the role of WHO in global health governance, enable the organisation to address its decade long financial crisis, and contribute to the realisation of the Sustainable Development Goals (SDGs). While the broad vision of GPW 13 is laudable, there are some areas of concern. The GPW does not discuss adequately proposals that would address WHO's long standing financial crisis, and its reliance on partnerships with actors linked to the private sector in the implementation of WHO's core agenda. Further, the GPW largely ignores issues related to the health workforce, especially issue of health worker migration from LMICs to HICs and the need to discuss remedial measures. The GPW also, unfortunately, skirts issues related to Intellectual Property Rights and the impact of the global IP regime on access to vital medical products.

Key Issues and Recommendations

Financial situation and normative work

GPW 13 does not adequately address the severity of the financial situation WHO is facing, and continues to adopt a vision of WHO's priority setting mechanism tied to funders priorities rather than of its own governing bodies. The GPW's reluctance to squarely address the impact of donor chokehold on its functioning can be seen from the fact that the final document diverges from the earlier draft and does not contain the earlier formulation which stated: *"The approval of WHO's Programme budget by Member States comes with an implicit commitment to ensure full financing [...]"*. This appears to absolve Member States of the responsibility to ensure full financing of WHO's budget through untied contributions.

Currently, around 80% of WHO's finances are in the form of earmarked donations and a major proportion of WHO's programmatic budget is funded by such earmarked funds. Strategies which are endorsed by the Assembly but which donors do not like, do not get implemented (for example the failure to implement the 2006 Trade and Health Resolution, [WHA59.26](#)).

The GPW recognises the importance of flexible financing in ensuring WHO's political independence. For instance, §110 states that: *"In order to finance and deliver on the three strategic priorities and obtain results in keeping with the ambitions of GPW 13, appropriate levels of more flexible, aligned and predictable funding are crucial."* Further, §130 states: *"Given the integrated nature of the work that is required to implement GPW 13, more flexible financing will be critical. The quality of funds is almost as important as their quantity. The Director-General has asked Member States to unearmark their contributions. This is a sign of trust and enables management to deliver. Increasing assessed contributions would also give WHO greater independence."*

However, GPW 13 does not offer a vision of how more flexible funds are going to be secured. Instead it proposes essentially cost cutting measures by repeatedly referring to 'cost-effectiveness' of its interventions.

PHM calls on member states to demand and commit to a schedule of increasing assessed contributions by 10% in each of the next three biennium. The proposed 3% increase in assessed contributions is too meagre to address WHO's financial crisis.

Universal health coverage (UHC) and SDGs

The GPW relies heavily on affirming commitment to is the implementation of UHC and SDGs. PHM considers it imperative that the larger vision of the WHO be informed by a rights based approach that incorporates the redistribution of power and wealth, within countries and between countries. It is crucial for the WHO to return to a comprehensive view of universal health care (and not just 'coverage'). However, the GPW's vision of UHC remains within the limited framework of preventing financial hardship to patients rather than ensuring universal access to adequate healthcare services through a unified health system that is publicly funded and largely premised on public services.

For instance, §28 emphasises access to 'essential' health care services and medicines, thus leaving open for interpretation considerations such as who defines what is essential. In many situation essential services are being defined as an extremely limited packages – a far cry from the vision of comprehensive health care in the Alma Ata Declaration.

Multi-stakeholder partnerships and conflict of interest

GPW 13 contains a strong emphasis on cooperation with non-state actors. This refers mainly to entities from the private sector. §14 says that: *"The 'triple billion' goal is a joint effort of Member States, WHO and other partners"*, while §35 reads: *"The private sector can also contribute to UHC in service delivery, innovation, investment, and as employers"*. Insisting on the concept of multi-stakeholder partnerships and relying on market based models to achieve universalisation of health care opens for a variety of conflicts of interest.

The GPW relies on the Framework of Engagement with Non-State Actors (FENSA, [WHA69.10](#)) as the principal means of managing of conflict of interest, but it ignores the fact that FENSA's effectiveness in managing Col is yet to be proven. §78 states: *"WHO's FENSA provides the guidance needed to engage in partnerships with all types of non-State actors while maintaining the Organization's integrity and independence from interests detrimental to health"*. §80 goes on: *"WHO will support private and public-sector investments in primary prevention, as appropriate, and will provide evidence-based guidance that supports healthy choices and interventions, applying the WHO FENSA as needed"*. The GPW, to summarise, appears to extend an open invitation to the private sector in core activities of the WHO while being deficient in addressing the possible ill effects of Conflicts of Interest.

PHM is concerned with the GPW's relative benevolence towards private entities, in particular transnational companies (TNCs). We urge MS to demand that WHO address the fact that many TNCs, through their operations, have a negative impact on people's health, and engage in treaty making processes which could effectively prevent conflicts of interest at all levels of health governance.

Health workforce

The importance of strengthening the health workforce across the globe is not adequately addressed in GPW13. The health workforce crisis is sought to be addressed, almost exclusively, through a reliance on the private sector. There are only a few direct references to the effects of health care worker migration on the stability of health systems, even though the adverse effects of this trends have been repeatedly confirmed.

§42 acknowledges that “*there is a growing mismatch between supply, need (SDG-based) and demand (ability to employ) resulting in skills and staff shortages, even in high-income countries*”. It also states that “*Projections to 2030 indicate that the investment needed for educating and employing sufficient health workers to achieve UHC equates to almost 50% of the cost of achieving SDG 3.*” It is a matter of concern that the GPW relies on the private sector to undertake the crucial task of health workforce training and education. It states: “*These challenges highlight the importance of, and need for, multisectoral engagement in order to respond to a dynamic labour market with interlinkages between education, employment, health, finance, gender and youth – cutting across SDGs 3, 4, 5 and 8.*”

If we want to build effective and resilient health systems and achieve Health for All, it is crucial that health workforce shortages are addressed. A number of WHO and ILO documents, as well as [a 2016 report](#) by the High-Level Commission on Health Employment and Economic Growth, underline the fact that health systems around the world are mostly understaffed and, therefore, not fully fulfilling their primary role.

The projected shortage of 18 million health workers by 2030 will be compounded by differences in distribution of health workers globally and within countries. Health worker gaps primarily affect the poorest populations, leading to serious obstacles in the achievement of health equity. The share of the population without access to health services due to health workforce shortages in 2014 has been estimated at 84% in low-income countries, and 55% and 23% in lower-middle-income and upper middle-income countries respectively.

Deteriorating working conditions inside the sector represent another problem for the health workforce. Following the entry of private healthcare providers and austerity-oriented reforms, conditions of employment in the health sector have deteriorated. In 2015, on an average, one third of the EU’s health sector workforce worked part time, ranging from 78.7% in the Netherlands to 4.1% in Slovakia. The ILO has cautioned that workers in non-standard work arrangements tend to be exposed to a number of deficits, including job insecurity, lower pay, and limited organizing and collective bargaining power.

Finally, we face the question of health workers’ migration. Low-income countries continue to train doctors and nurses, who then move to wealthier nations. Unfortunately, this trend has not been stopped by the introduction of the non-binding [Global Code of Practice on the International Recruitment of Health Personnel \(WHA63.16\)](#) in 2010. Such inadequacy of the existing framework for regulating health workers’ migration can be addressed through the introduction of compensation for LMIC that are losing health workers due to recruitment from high-income countries.

PHM urges WHO to take into account questions of health workforce when discussing all aspects of building health systems. WHO can play a role in supporting MS to build well-staffed public health care systems, robust training and education institutions within the public sector, instead of relying on provisions of care and education by the private sector. PHM also urges WHO and MS to create binding mechanisms for ethical forms of recruitment and fair compensation for LMICs.

11.4 Health, environment and climate change

“There is no task that is more urgent, more compelling or more sacred than that of protecting the climate of our planet for our children and grandchildren.” Christiana Figueres, Executive Secretary of the UNFCCC 2010-2016

Overall Background

International climate negotiations not sufficient to stop climate change

The United Nations Framework Convention on Climate Change (UNFCCC), was established in 1992 to provide a framework for governments to address dangerous human interference with the climate system. Since then, the parties meet annually at the Conference of Parties (COP) to discuss the convention’s progress and implementation. In 2015 the **Sustainable Development Goals (SDGs)** were adopted with **Goal 13** calling on governments to “take urgent action to combat climate change and its impacts.” COP21 subsequently represented a significant milestone in climate change negotiations with the adoption of “**The Paris Agreement**” by consensus that outlined the central aim to keep the global temperature rise well below 2 °C, above pre-industrial temperature levels. Parties also agreed to “endeavour” for a temperature rise below 1.5°C. The Agreement cites the “right to health,” showcasing a new international understanding, previously lacking, of the serious threat of climate change to health.

Despite this positive movement in international climate change negotiations, evidence shows that limiting warming to below 1.5 °C and preventing the serious health impacts, would require prompt reductions in global emissions to at or below 1990 levels by the middle of this century. There has been substantial criticism of current commitments as to whether they are sufficient to address the climate crisis. The effectiveness of the Agreement is significantly limited by the unwillingness to ratify by some major countries responsible for significant greenhouse gas emissions.

Strengthening WHO’s role

The WHA61 in 2008 passed a pivotal resolution highlighting the negative impacts of climate change on health with a view to supporting member states in the protection of human health from climate change.

The WHO’s first [Climate and Health Workplan 2008-2013](#) was adopted in [EB124.R5](#) followed by a revised plan (2014-2019) after the first WHO Conference on Health and Climate in 2014. [EB139/6](#) (May 2016) further requested the Secretariat to prepare another revision of the [2014-19 plan](#) taking into account new strategic priorities.

The WHO UNFCCC - Climate and Health Country Profile Project is tracking national progress on climate action in the health sector through a biennial WHO country survey. A series of climate and health country profiles are also to be released in 2019 following the publication of the 2015 series that is currently available.

11.4 Health, environment and climate change

Background

This policy brief refers to agenda item 11.4 Health, environment and climate change of the 71st World Health Assembly (WHA71) and accompanying documents A71/10, A71/10 Add.1, and A71/11.

Health, environment and climate change

At the 142nd session of the Executive Board ([EB142/5](#)) in January 2018, the Director General was tasked with developing a **draft comprehensive global strategy on health, environment and climate change** for consideration at EB 144 in January 2019, and by Member States at WHA72. The Report

[\(A71/10\)](#) provides an interim overview of the topic and thus presents an important opportunity for Member States to continue discussions on this issue and provide useful input to the comprehensive global strategy on health, environment and climate change in advance of the final decision at WHA72.

[A71/10](#) summarises the continuing disease burden associated with environmental degradation and global warming. It reviews the current status of the public health response to environmental risks including global warming and **calls for transformational change for more effective upstream action in accordance with the SDGs**. It highlights the need for the WHO to play a stronger role in this response and to fulfill its mandate to “act as the directing and coordinating authority on international health work”. The need for increasing the decreasing human and financial resources directed at the environment and climate change at national and international levels is also highlighted.

The Report draws particular attention to the impact that climate change will have on Small Island Developing States (SIDS), and highlights WHO’s response: its application to the Green Climate Fund for accreditation, and the launch of its Special Initiative to address climate change impact on health in Small Island Developing States.

Climate change in small island developing states

[A71/10](#) states “the absence of strong measures to cut carbon emissions and protect populations from the effects of climate change, rising sea levels will submerge extensive and densely populated coastal areas, including some entire small island nations, by the end of this century”. The Executive Board (in [EB142\(5\)](#)) requested the DG to prepare a draft action plan to address the health effects of climate change in Small Island Developing States (SIDS), also to be considered by WHA72 in May 2019, through EB144 in January 2019.

Human health and biodiversity

At WHA71, the WHO secretariat will be submitting a report on human health and biodiversity to be noted by the Assembly ([A71/11](#)). The brief of the secretariat is quite specific: “to prepare a report on actions taken on the interlinkages”. Thus, the report includes an overview of the context and policy mandate and biodiversity and health links. It also outlines the collaborative activities on biodiversity and health that have taken place as well as the Secretariat’s plan of action and suggestion of activities for Member States.

[A71/11](#) also outlines a set of actions planned for the Secretariat under the joint work program with the Secretariat of the CBD and as a contribution to the 14th COP. This set of planned actions also includes support to member states in building awareness and collaboration and undertaking policy initiatives at the country level.

The [State of Knowledge Review](#) outlines a set of links where biodiversity and the integrity of ecosystems support human health directly. These include issues such as food security, access to clean water, destruction of human ecosystems and others. These are likely to impact health, through pandemic risk, food security and the destruction of living spaces. Further actions and policy directions can be found in the COP13 Decision [XIII/6](#) and its Annex.

Air Pollution

In 2016 at the 69th WHA, Member States reviewed a “road map” prepared by the Director General for “an enhanced global response to the adverse health effects of air pollution”, and requested a further report on the road map progress (A71/10 Add.1)

Analysis

Health, environment and climate change

Recognizing that climate change represents an urgent and potentially irreversible threat to global health, People's Health Movement applaud the DG for his commitment to action on climate change and other issues of environmental destabilisation and appreciates the decision to develop an Action Plan and Global Strategy on the environment and climate change.

PHM particularly appreciates:

- the focus on the SDGs;
- the explicit mention of fossil fuels as drivers of climate change
- the emphasis on the intersectoral nature of the policy issues, including “production methods that pollute, deleterious consumption and distribution patterns and disruption of ecosystems.” (Para 19)
- the recognition of the role of “politically and economically powerful and multinational, private-sector actors” (para 12);
- the acknowledgement of the health and economic benefits of carbon pricing/taxation (para 21); and
- the references to research, evaluation and evidence.

However, there are also several topics that PHM would like to highlight to Member States on the issue of health, environment and climate change.

The need for urgent and immediate action

While PHM applauds WHO for making climate change a priority health issue, the urgency of the situation is at odds with WHO's decision to defer to 2019 discussion with Member States. Antonio Guterres summed up the situation at the Australian World Summit last week "Climate change is, quite simply, an existential threat for most life on the planet – including, and especially, the life of humankind." As the planet exceeds 410ppm for the first time in human history, and in April 2018 Nawabsha in Bangladesh experienced the hottest temperature ever recorded - 50.2°C (122.36°F) - climate change must not become a biennial discussion point.

Disease burden attributable to modifiable environmental factors

Clearly identifying disease burden attributable to modifiable environmental factors is a good starting place for prioritising and strategising.

Distributional issues

Disease burden and exposures are not uniformly distributed. We have to note uneven distribution of disease burden and exposures between low and middle income countries and high income countries, within societies, between gender, by occupational group and by age, which are likely to increase over time.

Priority intersectoral issues

Virtually all of the environmental health challenges are intersectoral which suggests that health sector strategies need to be packaged in terms which make sense in the context of whole-of-government decision making.

Transport, energy and food systems/ the agricultural sector need to incorporate and work on climate change mitigation and adaptation in an intersectoral manner.

Regulatory and governance capacity

The necessary regulatory and governance capacity, particularly at the global level, is generally lacking. Measures such as control of carbon emissions (through pricing and taxing), assessing impact of trade agreements on public health and the environment, regulation of corporations and industries,

participatory engagement of public, green structural change and research, need such governance. We emphasise that the WHO must play a fundamental role in providing and supporting such governance.

This must include issues around the political economy of social and economic development. Transnational corporations undermining the efforts to reduce emissions should be regulated globally, and the recognition that national competing tax policies undermine these efforts equally.

An Action Plan and Global Strategy which fails to engage with these forces will have little impact.

Health sector issues

In order to effectively engage in intersectoral collaboration around environmental health, the health sector needs significant capacity building around whole of government policy analysis, development, implementation, and monitoring. In particular there is a need to strengthen the role of primary health care in policy advocacy and community engagement around environmental issues.

Small island states

In the draft action plan to address the health effects of climate change in small island developing states for consideration in 2019 is likely to focus on: global advocacy around climate change mitigation, fund raising and increased financial support for preparedness, prevention, protection and resilience. PHM applauds this initiative.

Human health and biodiversity

PHM appreciates the decision to develop an Action Plan and Global Strategy and comment the Secretariat report, but urges member states to authorize the Secretariat to include the actions and strategies needed to address the interlinkages (between biodiversity and health) in the draft Action Plan and Global Strategy (for health, environment and climate change) to be developed for consideration and adoption in 2019.

Key Issues and recommendations

- We appreciate the decision to develop an Action Plan and Global Strategy and commend the Secretariat report.
- We maintain that the WHO must claim a fundamental governance role by reaffirming its mandate to “act as the directing and coordinating authority on international health work” with respect to health, environment and climate change.
- We urge the WHO to not only utilize existing legally-binding multilateral environmental agreements - such as the UNFCCC - but to instigate further binding frameworks, for example on Air Pollution, one of the most prevalent environmental problems, following the principles outlined in the road map for an enhanced global response to the adverse health effects of air pollution (A71/10 Add.1).
- Member states must acknowledge and act upon their shared responsibility for the reduction in air pollution and the costs in doing so, especially by supporting low and middle income countries in transitioning to cleaner technologies and in carrying out climate change mitigation and adaptation measures.
- The WHO must recognize the polluter pays principle - most of the corporate sector and industries are in the global North, yet have relocated their polluting industries to the global South, thus hiding the real drivers of pollution.
- The WHO must provide governance and technical assistance to member states on prioritising environmental action and public health over profit.
- The WHO must encourage divestment and phasing-out of fossil fuels who are cause of a double-burden to the environment and health, through measures such as carbon-taxing.

Issues in the Agenda of WHA71 related to Access to Medicines

1. Overall background

Issues that compromise access to medicines affect all countries. Millions of people die because they are not able to afford essential and lifesaving medicines. While LMICs continue to bear the major burden related to lack of access to medicines, patients in HICs are also starting to encounter major barriers to access. In addition, diagnostics, vaccines and medicines are just not available for many diseases, revealing that the current system of market-driven R&D fails to effectively address public health needs.

The market driven R&D system is broken

Since the adoption of the **TRIPS Agreement** (and the following harmonization of patent laws across the world), persistent challenges have merged in many countries with regards to the full use of **TRIPS flexibilities** for public health protection. Moreover, **Free Trade Agreements (FTAs)** routinely include **TRIPS+ provisions**, which undermine the ability of States to adopt and make full use of TRIPS flexibilities to promote public health. A recent example is the threat by Novartis to refer to international arbitration mechanisms in order to avoid the issuing of a compulsory license.¹

The current Research and Development (R&D) framework relies on countries granting patent monopolies to pharmaceutical companies as the main way to incentivize innovation. This leads to innovation being focused on diseases affecting wealthy patients and leaves many gaps in development of drugs which are needed for diseases, especially those that affect the poor. New drugs which are effective are often unaffordable for the majority, as we have witnessed in the case of new Hepatitis C drugs.

United Nations High Level Panel on Access to Medicines report

In September 2016, the UNHLP released its final report, including recommendations to address the global challenges caused by high prices of medicines and lack of health needs-driven innovation. The report recognizes that (lack of) access to medicines is, now, a global issue and propose recommendations in three subtopics:

- 1) **Intellectual Property Laws and access to Health Technologies:** including the use of the flexibilities of the TRIPS Agreement and the need for publicly funded research on new technologies.
- 2) **New incentives for R&D of Health Technologies:** including a binding R&D convention that delinks the costs of research and development from end prices to promote technology innovation.
- 3) **Governance, accountability and transparency:** including assessment of health technologies, creation of a multistakeholder force for health innovation under the UN, transparency on clinical trials and the development of an international database for patents, in coordination with WIPO.

¹[https://www.publiceye.ch/en/media/press-release/compulsory licensing in colombia leaked documents show aggressive lobbying by novartis/](https://www.publiceye.ch/en/media/press-release/compulsory%20licensing%20in%20colombia%20leaked%20documents%20show%20aggressive%20lobbying%20by%20novartis/)
<http://www.consilium.europa.eu/en/press/press-releases/2016/06/17-epsco-conclusions-balancepharmaceutical-system/>

2. Specific Agenda Items

11.5: Addressing the global shortage of, access to, medicines and vaccines

Background

After the UNHLP report was published, several Member States had demanded that its findings be fully discussed in the WHO. However, a substantial debate on the document was never really held due to the opposition of countries with a large presence of the pharmaceutical industry (led by the United States, Japan and others). During WHA70, in May 2017, the discussion of the inclusion of the recommendations of the UNHLP was held under this agenda item. The agenda item covers both - the issue of access to medicines, and then the issue of shortages. This was seen by many as a ploy to dilute the debate on both these issues.

At EB 142, it was decided to address the issue within a broad whole-of-supply-chain canvas. The Assembly is now invited to request the DG to elaborate a **roadmap report outlining the programming of WHO's work on access to medicines and vaccines, including activities, actions and deliverables for the period of 2019 – 2023** and to submit that roadmap report to WHA72 in May 2019.

The document presented to the Assembly, [A71/12](#), notes that WHO is already engaged in a range of activities which address most of the recommendations of the [High Level Panel Report](#). Appendix 3 to the Annex in A71/12 lists the recommendations of the HLP report and summarizes relevant work currently undertaken by the Secretariat.

Analysis

Proposed Roadmap

PHM urges member states to support the proposed decision on creating and adopting a roadmap. However, the proposal in its current form, is inadequate.

Prioritization of actions taken

A total of 33 'key considerations', drawn from the list of actions and a series of priority actions for the Secretariat, have been identified in the document. These are further prioritized in terms of impact, complexity and cost as:

1. high impact, low complexity and low cost
2. high impact but more costly and more complex
3. highly complex and expensive

The prioritization based on cost and complexity is problematic as it fails to reflect the relative importance of the actions undertaken. The set of actions defined as high complexity and expensive play a central role in addressing access to medicines and such a definition could discourage adoption of these by member states. These include:

- Support the development, implementation and monitoring of national medicines policies to reinforce strategies for the appropriate use of medicines.
- Tackling undue influence and corruption in the pharmaceutical system, particularly in procurement and supply chain management.
- Facilitate discussion on unifying principles for biomedical research and development.

Therefore, we would like to suggest that **prioritization be based on impact**.

Lack of focus on 'delinkage'

The commitment to 'delinkage', a central element in improving access, is weak. Prices of drugs and other health technologies should not be linked to research costs but should be largely aligned to manufacturing costs. The result of research leading to new products should always be public, and the cost of development should be supported by public funds.

The lack of reliable information regarding the cost of R&D impedes policies directed at reduction of the prices of medical products. It is not possible to arrive at an accurate estimate of private sector expenditure in R&D. What we do know, however, is that an overwhelming proportion of upstream costs on R&D are supported by publicly funded institutions.

Funding and implementation

The deliberate underfunding of WHO prevents full implementation of the resolutions listed in Appendix 1. WHO has been repeatedly prevented from fully implementing resolutions which Big Pharma opposes. WHO should provide technical assistance, especially to LMICs, on in the use of legal ways (for example the TRIPS flexibilities) to ensure that health technologies are affordable and widely available.

Introduction of Low Cost Biological Drugs (Biosimilars)

Biological drugs offer treatment for several diseases – cancers and autoimmune disorder – for which treatments were earlier not available. However they are among the most expensive drugs and unaffordable for most patients. Lower cost follow on versions (called biosimilars) are now available but their introduction is blocked by onerous regulatory barriers. WHO's biosimilar guidelines have not moved on with developments in technology and are proving to be barriers to countries which follow these guidelines. We urge on Member States to ensure that WHO'S guidelines are modified to facilitate the entry of biosimilars.

What the Roadmap should look like

Member states need to give the Secretariat a clear mandate regarding the draft road map, including an endorsement of 'delinkage', prioritisation on the basis of impact rather than cost and complexity, and a commitment to fully funding the program.

The following points should be included in the roadmap:

- A commitment to the concept of de-linkage as recommended in the UNHLP report
- WHO's role in providing technical support to Member States who wish to use the TRIPS flexibilities
- Providing information and technical support to Member States with regards to bilateral and multilateral trade agreements and their impact on the use of TRIPS flexibilities (preventing so called 'TRIPS+' provisions)
- Support of publicly funded research and its central role in access to health technologies
- The need for a R&D system driven by public health needs, that takes into account epidemiological factors and social determinants of health
- Transparency on drug development and manufacturing costs needed to inform drug pricing policies

- The development of a framework for transparency on clinical trials, such as a database with public access
- A modification of WHO's guidelines on biological drugs so as to facilitate entry of low cost biosimilars

11.6 Global Strategy and plan of action (GSPoA) on public health, innovation, and intellectual property

The GSPoA proposes that WHO should play a strategic and central role in mediating the relationship between public health and innovation and intellectual property. It has been 10 years since the GSPoA was introduced and it is yet to be implemented. The original goal of the GSPoA was to promote new thinking on innovation and access to medicines and to secure an enhanced and sustainable basis for needs-driven essential health research and development relevant to diseases that disproportionately affect developing countries.

Overall Program Review

EB142(4) is a draft decision to implement those recommendations of the Overall Program Review (OPR), which would authorize the DG to develop and enact an implementation plan regarding the recommendations by the OPR to the Secretariat, set out as priority actions in A71/13. The OPR proposes 33 measurable, action and time specific indicators. Responsibilities for specific actions are assigned to WHO and Member States. The report outlines critical issues around financing and asks for Member States to commit to dedicating at least 0.01% of their gross domestic product to basic and applied research relevant to the health needs of developing countries. This is in the background of evidence that R&D around for II and Type III diseases remains grossly inadequate.

Analysis

The aims and targets of the GSPOA remain valid and crucial for access to medicines and we strongly support the implementation and funding of the GSPoA. We especially support the envisioned prioritization of research and development needs, promotion of research and development (including transparency of R&D costs and publication of results) and support to use TRIPS flexibilities, as well as the inclusion of the concept of de-linkage.

As the report rightly outlines, implementation of the GSPOA remains the main issue. PHM urges member states to implement and fund the activities outlined in the GSPOA and support the financial contribution envisioned by the report.

The cost of implementing all the recommendations across the four years, 2019-22, is estimated at \$31.5m for the full set of recommendations and \$16.3m for the high priority actions. If these costs are not covered, further delay in actions on the GSPoA can be anticipated. Previous evaluations of the GSPOA outlined a very weak engagement of MS with the process, and this lack of awareness is linked to the lack of funding, as well as the continuing opposition by certain member states that has promoted the deliberate underfunding of the GSPoA.

Unfortunately, **no timeline** for implementation has been suggested. We urge MS and the Secretariat to set a clear timeline for progress, as people who are in need of life saving and essential medicines cannot afford another 10 years delay in action.

Binding R&D Treaty

We also remind MS and the WHO that the **envisioned binding R&D treaty was** supposed to be a key outcome of the process. The WHO has the constitutional mandate to craft such a treaty and we urge MS to support the drafting a binding R&D treaty.

11.8 Preparation for a high-level Meeting of the General Assembly on ending tuberculosis

Background

TB mortality and incidence rates are reported to be decreasing annually at about 3% and 2% respectively. However, by 2020 the annual rates of reduction need to be 4-5% and 10% in order to reach the 2020 milestones of the End TB strategy. There is therefore an urgent need to galvanize political commitment to battle against TB. (data provided in the document)

EB142 adopted a draft resolution on preparation for a high-level meeting of the General Assembly on ending TB which will be held later in 2018. The board requested the DG to support the implementation of the Moscow Declaration to end TB. Adopted by 118 national delegations, the Moscow Declaration calls to accelerate efforts to set targets in WHO's end TB strategy. The Assembly is invited to adopt the draft resolution recommended by the EB142.

Analysis

Although addressing TB goes far beyond the issue of access to medicines², it is important to emphasize that the non-availability of new TB medicines is an example of how the profit driven R&D systems fails to address critical health priorities.

What is urgently needed is research collaboration in developing new treatments and also measures to make a full use of TRIPS flexibilities. This issue is particularly pressing with the rise of multi-drug resistant MDR-TB. Several new anti-TB drugs are becoming available now and it is critical that secure access to these drugs is ensured for those most in need.

This issue is particularly relevant in the context of the upcoming high level meeting of the UN General Assembly and we urge MS to recognize these points as crucial elements for the upcoming negotiations. We would also like MS consider negotiating a system for waiver on product patents for new anti-TB medicines.

12.1: Global Snakebite burden

Background

The inclusion of snakebite burden in the WHO's agenda is welcome. In March 2017 snakebite envenoming was recommended to be included in the WHO's NTD portfolio as a Category A Neglected tropical disease. In May 2017, the Director-General endorsed the recommendation and in June 2017, snakebite envenoming was finally added to the list. WHO data suggests that there are an estimated 1.9m - 2.7m cases of envenoming each year worldwide This results in about 400 000 cases with serious injuries and disabilities and 81 000 - 138 000 deaths (A71/17).

² For more info on TB:

WHO, Global Tuberculosis Report, 2017 pp. 218-224

<http://apps.who.int/iris/bitstream/handle/10665/259366/9789241565516-eng.pdf?sequence=1>

'Although snakebite does not have the epidemic potential of infectious and vector-borne parasitic diseases, yearly mortality caused by snake bite is much greater than that attributed to several more recognised NTDs. Moreover, snakebite envenoming disproportionately affects disadvantaged rural populations in tropical and subtropical countries with limited access to adequate health services.

Access to safe, effective, life-saving antivenoms is one of the most important obstacles in addressing the snakebite burden. The current cost of effective antivenoms can range from USD 55 to USD 640 in Sub-Saharan Africa, to up to USD 5 150 in India.

This price doesn't include the additional long-term cost in follow up care. The extremely high price of antivenoms reinforces the poverty cycle that populations affected are trapped within. This results in victims of envenoming either not seeking treatment or receiving sub-optimal dose treatment they are able to afford. Further, antivenoms need to be appropriately manufactured and need to be quality assured products. Poor control and regulation of snake antivenom preparation is an additional challenge.

WHO Response

The Secretariat had established a working group on snakebite envenoming to assist in the development of a strategic plan for this disease. The WHO notes that it is essential to mobilize additional resources to tackle this issue and intensify efforts to advocate for improved surveillance and control of snakebite envenoming.

Analysis

Snakebite envenoming is yet another example of the failed R&D system. There are also issues linked to supply chain mechanisms and manufacturing.

We urge MS to introduce solutions for public manufacturing, at the national or regional levels. We would also urge WHO to uphold its promise of a greater financial commitment to snakebite envenoming in particular, and the wider area of Neglected Tropical Diseases in general. Finally, strategies to incentivise antivenom production for different kind of antivenoms - including scorpion or spider antivenom -- should be also addressed by the WHO.

12.8: Rheumatic fever and rheumatic heart disease

Background

Rheumatic fever (RF) is an autoimmune response to a group A streptococcal throat infection. The incidence of RF in low- and middle-income countries and in marginalised communities in high-income countries remains high. Indigenous populations of the Pacific region have some of the highest incidences recorded in recent years with 375 per 100 000 per year in those aged 5 - 14 years. Around 60% of these patients develop rheumatic heart disease. One of the main risk factors are socio-economic and environmental conditions such as poor housing, overcrowding, undernutrition & lack of access to medical services.

The Assembly is invited to adopt the draft Resolution recommended by the EB141.R1 and to note document A71/25,

Analysis

Poor primary and secondary prevention and access to primary health care is one of the major barriers to progress in tackling RF and RHD. Although the scope of prevention and elimination of RF and RHD goes far beyond the debate on access to medicines, it is important to highlight that an effective primary prevention can be achieved through effective treatment of streptococcal pharyngitis with penicillin.

Additionally, new vaccines are needed to enable global reduction in incidence of all syndromes related to group A streptococci. Secondary prevention of RF and RHD can be achieved through the administration of benzathine benzylpenicillin to patients with a previous history of RF and/or RHD.

It is therefore of significant importance to ensure the continuous supply of quality-assured and affordable penicillins and advance a prioritised research agenda aimed at better understanding of the epidemiology and pathogenesis of this disease to support the research and development of a group A streptococcal vaccine and a long-acting penicillin formulation.

4. Overall Recommendations

PHM urges Member States to take up following actions with regards to the above mentioned agenda items:

11.5 Access to medicines:

- To support the decision of the EB142 and to give to the Secretariat a **clear mandate for the roadmap**, including de-linkage, the need for public funds for research and the consequences of the current patent-driven system
- To address the **UNHLP recommendations** at WHA71 and to include it in the roadmap
- To address the issue of the need to **facilitate entry of lower cost generic (biosimilar) versions of biological drugs**.

11.6 GSPOA:

- To implement and **fund** the activities outlined in the GSPOA and supports the increased contributions as envisioned by the report
- To give a **concrete time frame** of when the plan would be implemented

11.8 Ending TB:

- To recognise **the barriers to R&D of new TB medicines**, their affordability and accessibility as one of the crucial elements for the upcoming negotiations with regards to the Ending TB strategy
- To set up a system to waive all patents on new anti-TB drugs

12.1 Snakebite burden:

- To promote R&D of high-quality and affordable snake antivenoms as well as improve **supply chain of these treatments** through public manufacturing

- To ensure the development of **standardised regulatory mechanisms** for R&D of snake antivenoms
- Uphold its promise of a greater **financial commitment** to snakebite envenoming in particular, and the wider area of Neglected Tropical Diseases in general

12.8 RF & RHD:

- Ensure **continuous supply** of quality-assured and affordable penicillin
- Advance a **prioritized research agenda** aimed at better understanding of the epidemiology and pathogenesis of this disease to support the **research and development** of a group A streptococcal vaccine and newer prophylactic drugs.

Further, PHM would like Member States to:

- Convene an **inclusive open-ended meeting as soon as possible**, as proposed in WHO documents and recommended by the UNHLP, where the **negotiation of an R&D Convention** is discussed. Such binding international instrument should be based on de-linkage and principles promoting public health.
- **Ensure long-term sustainable financing** of the above mentioned programmes to ensure their implementation

12.3 Global Strategy for Women’s, Children’s and Adolescents’ Health (2016–2030): sexual and reproductive health, interpersonal violence, and early childhood development

Background

Launched by the UN Secretary General in September 2015, the strategy identifies nine action areas and it links the action to the implementation of a suite of evidence-based health interventions. Additionally, it notes the commitment of the ‘H6 partnership’ (UNAIDS, UNFPA, UNICEF, UN Women, WHO, and the World Bank Group) in the provision of technical support and finance centred on the Global Financing Facility (GFF) for LMICs hosted by the World Bank. It stresses accountability based on the agreed indicator framework and the Independent Accountability Panel.

The first report following the adoption of the Operational Plan (in WHA69.2) was carried in A70/37 in May 2017. This report gave an outline of progress in women’s, children’s and adolescents’ health and included a separate section focussing on adolescents’ health.

A71/19 is the second annual report, and provides information of the current situation with respect to the epidemiology and policy/program implementation for women’s, children’s and adolescents’ health, including sexual, reproductive health, interpersonal violence and early childhood development. The document foreshadows a report on midwifery next year. The Secretariat is invited to note the report.

PHM Analysis

At the outset PHM would like to point out that the continuous conflation of women’s health with child health, and now with adolescent health, is a notion embedded in patriarchal values regarding women’s role and position in society. Women’s health needs are not just linked to their reproductive role and their broader needs need to be addressed in a meaningful manner.

The Global Strategy and the Operational Plan anticipates a range of prudent and strategic initiatives. The barriers to achieving the objectives of the strategy and effectively implementing the various initiatives and interventions are huge. The bureaucratic superstructure which has been erected around the implementation of the Strategy is reinforcing its complexity.

Some of the problematic areas revolve around following themes:

Women’s rights and reproductive and sexual health

Social structures, with historical and regional differences, encompass all aspects of women’s lives and determines and mediates the reproduction and reproductive choices. In other words, women’s self-determination in childbearing (if, when and with whom to have children) is influenced by systems of gender relations and these are embedded in socio-ecological, economic and political structures.

While one may argue that there are clear examples of significant improvement over the years for women’s health (e.g. significant improvements in reducing maternal mortality), women and girls account for 71% of all human trafficking victims detected globally (UN data), and 1 in 3 of women worldwide have experienced either physical and/or sexual intimate partner violence or non-partner sexual violence in their lifetime (UN data). This indicates that mainstream reproductive and sexual health programmes do not address their main objective of “empowerment, including for promotion of their sexual and reproductive health and rights [in order to build] sustainable and equitable development of societies” (Fiftieth Commission on Population and Development WHO, New York,

2017). Additionally, this “empowerment” should go beyond sex-based inequalities, for example, 23% of lesbian, gay, bisexual, and transgender interviewed in the EU indicated having experienced physical and/or sexual violence by both male and female non-partner perpetrators (UN data).

Family planning

Family planning measures are useful in preventing additional morbidity and mortality in woman of childbearing age. However, contraceptive technologies alone, do not promote women’s empowerment. The mere promotion of contraceptive technologies do not ensure that decisions related to family planning and contraception use are controlled by 3women themselves. Family planning programs direct their interventions almost exclusively at women, from the contraceptive methods developed and deployed, to information, education and communication activities.

Family planning is an integral part of overall strategies to combat women's subordination but access to and command over material and nonmaterial resources far beyond contraceptives and family planning programs are needed. They should substitute as their objective the safeguarding and enhancement of women’s health, general welfare and social position of women in society. Additionally, partners should be integrated as active actors in both fertility decisions and family planning users, but in a context, which prioritizes women's needs rather than subordinating women's well-being to demographic imperatives.

Finally, many family planning programmes are based in the work of women as CHWs which are integrated in the health system as unpaid or low paid and devalued work. Governments should recognize CHWs as regular workers and provide for stable and regular wages for all CHWs and ensure that payments are made in a timely manner.

Abortion

Legal restrictions on abortion services in many countries lead to unsafe abortions, which endanger the lives of thousands of women contribute to the mortality and associated health complications of women and adolescents. Some 68,000 women die of unsafe abortion annually, making it one of the leading causes of maternal mortality (13%). Additionally, the annual cost of treating major complications from unsafe abortion is estimated at US\$ 553 million (WHO data). Compelling evidence demonstrates that liberalizing abortion laws to allow services to be provided openly by skilled health personnel reduce the rate of abortion-related morbidity and mortality.

It is important to note the open-access Global Abortion Policies Database, containing abortion laws, policies, health standards and guidelines for all WHO and United Nations Member States.

The Global Gag rule, reinstated by the US government, poses a risk to women’s health and lives by forcing NGOs to choose between receiving U.S. global health assistance and providing comprehensive sexual and reproductive health care. The Global Gag Rule’s negative effects are wide-ranging. The policy reduced access to sexual and reproductive health services. The Global Gag Rule reinforces the longstanding separation between abortion and family planning services, making it difficult to lower rates of unsafe abortions and maternal mortality, and has a negative impact on women’s health in general. In the global south, especially in remote areas, it has affected community based distribution (CBD) programs targeting the youth. The compelling evidence regarding unsafe abortions should be used to reverse the gag rule.

Early Childhood Care and Development

As seen in the report (2018 monitoring report), neonatal mortality rate, under-5 mortality rate and prevalence of stunting still remain grossly unequal when compared across regions. Sub-Saharan Africa continues to have an under-5 mortality rate of 79 when compared to 4 in Australia & New Zealand and 6 in Europe. Moreover, the rate of decline in U5MR is too slow in many LMICs, especially in Sub Saharan Africa. PHM urges member states to consider the following drivers of ill health among children, as they are the major upstream causes that need to be addressed.

Children and their health remains most vulnerable in the early years and a healthy childhood is the foundation for healthy adulthood. Major determinants of ill health during childhood include sub-optimal nutrition, unhealthy environment and lack of opportunities for development of cognitive skills and these need to be addressed as a priority.

PHM would also like to raise the need for early intervention as a major part of Early Childhood Care and Development. Issues such as birth defects, developmental delays and disabilities (physical, cognitive, sensory and learning), need to be addressed through initiatives such as screening and early interventions can be a powerful tool in increase a child's independence, in their ability to accessing quality education services and in and growing up to be healthy individuals.

Health systems need to be strengthened and have a clear focus on community based interventions provided through community health workers. Such interventions should be supported by optimal Human Resources for Health, including paediatricians, occupational therapists, paediatric physiotherapists, rehabilitation nurses, and necessary welfare measures. Extending these measures will be instrumental in enhancing the quality of life of children and their families.

Poverty, social inequalities, lack of government spending coupled with situations such as conflict, migration are putting large population of children at risk of malnutrition and related health conditions. Problems of hunger and undernutrition, largely concentrated in the LMICs, are now accompanied by a rise in obesity among children in LMICS as well.

Across the world, inequity is rising as regards the neglect of child health between countries and within countries. These inequities are a consequence of economic inequalities rooted in an unfair global economic system. In order to address these problems, it is necessary to reshape the political and economic architecture of the global economic system by tackling the roots of inequalities between and within the countries through a fairer redistribution of resources.

Health financing and the Global Financing Facility (GFF)³

GFF is a multidonor trust fund managed by the World Bank. The resources are earmarked for reproductive, maternal, neonatal, child, and adolescent health and nutrition (RMNCAH-N), it is based in 'results' based financing interventions for investing in RMNCAH-N. Global Financing Facility Trust Fund have currently been allocated to 26 countries (as at July 2017, US\$ 525 million had been contributed). Country programmes are financed by linking grants from the trust fund with credit from the World Bank's concessional lending arm IDA. The combination of grants and debts (each USD of grant, WB matches US\$ 4) may lead to new debt crisis in LMIC and hamper the fiscal space of countries in the long run.

³ This section has been contributed by WEMOS

GFF resources are earmarked for RMNCAH-N and may therefore divert resources from other important national health or non-health targets

Performance based financing (PBF) is a central feature of the GFF financing mechanisms of Investment Cases. Due to the lack of implementing capacity in many healthcare settings, PBF can lead to already well documented risks (e. g. deviation of financial resources to specific interventions, lacking domestic ownership, focusing on fragmented areas of a health system rather than following a holistic approach). Thus, it finally does not provide the anticipated stimulating effect of higher quality and more efficient use of resources through strategic purchasing, but the contrary.

The report of the DG mentions the GFF as a financing investment in women, children and adolescents. While this is true, the GFF can only be seen as part of the solution of sufficient resource mobilization and is under no circumstances a magic bullet to overcome the challenge. Later on, the report also mentions the needed investment in early childhood development but once again falls short in mentioning specific steps to be taken to come closer to sufficient resource generation. Thus, the report misses fundamentally the opportunity of emphasizing the importance of increasing fiscal space and domestic resource mobilization for women`s children`s and adolescent`s health, as well as the responsibility of external donors` funding, and the creation of innovative mechanisms to do so, perhaps in the naïve belief that all aspects are already covered by merely mentioning the GFF. Therefore, no new information is provided on the implementation status of action area No. 2, namely financing for health, and moreover, the topic does not receive the important emphasis it urgently needs.

12.6 Maternal, infant and young child nutrition: Comprehensive implementation plan Biennial report, conflict of interest

Comprehensive implementation plan on maternal, infant and young child nutrition

Background

This policy brief refers to agenda item 12.6 of the 71st World Health Assembly ([A71/23](#)) which in turn draws on discussion and analysis presented at the 142nd session of the Executive Board ([EB142/23](#)). This item covers the Comprehensive Implementation Plan on Maternal, Infant and Young Child Nutrition: Biennial Report and efforts aimed at Safeguarding Against Possible Conflicts of Interest in nutrition programmes. WHO Resolution WHA65/6 endorsed the Comprehensive Implementation Plan (CIP) for 2012-2025 with six global targets on maternal, infant and young child nutrition to 2030 in order to synchronize them with the SDGs, and has proposed an additional four indicators that should be added to the Global Monitoring Framework on maternal, infant and young child nutrition. These four indicators are: (1) minimum dietary diversity; (2) antenatal iron supplementation; (3) availability of national-level provision of counseling services in public health and/or nutrition programmes; and (4) trained nutrition professional density.

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

However, as findings, DG's biennial report on the comprehensive implementation plan on maternal, infant and young child nutrition A71/22 shows no change in the reduction of anemia, with a 6% increase in overweight of children under-5 from 31 million in 2,000 to 41 million in 2016 (with 12% in Southern Africa, 11% in Central Asia and 10% in northern Africa). The report also shows that an estimated 60% of infants under 6 months of age are not exclusively breastfed. It also highlights that an estimated 52 million children under-5 suffered from 'wasting' in 2016, among whom 69% live in Asia and 27% in Africa.

Despite this record, countries are hopeful and have expressed the ambition of achieving the global goal of ending all forms of malnutrition by 2030, including achieving the "internationally agreed targets" on stunting (50%) and wasting (<3%) in children under 5 years of age.

PHM's analysis and recommendations

PHM views the Comprehensive Implementation Plan as a useful instrument in making progress towards the improvement of maternal and child nutrition globally. Notwithstanding, the plan needs to be modified to address global food systems. Global nutrition situation is poor, particularly in South Asia and Africa (in some cases, non-existent). The UN system is populated by numerous UN agencies, global PPPs, global philanthropies with different mandates, accountabilities and strategic frameworks, with a huge emphasis at the global level on (voluntary) 'commitments' and token institutional reforms. **PHM reaffirms that nutrition can only be addressed in the context of vibrant and sovereign local food systems that are deeply ecologically rooted, environmentally sound and culturally and socially appropriate.** Tackling global poverty and inequality and returning to ecological sustainability requires a radical rejection of economic globalization and neoliberal hegemony.

PHM urges WHO to support member states to **address the need for adequate human and financial resources** as these impede the effective implementation of nutrition interventions designed to safeguard the lives of mothers, children, and the entire population.

Safeguarding against possible conflicts of interest in nutrition programmes

Background

In 2012, at the 65th World Health Assembly, Member States agreed to establish a process for establishing “adequate mechanisms to safeguard against potential conflict of interest” between Member States and non-State actors (A71/23 para.1) while endorsing the comprehensive implementation plan on maternal, infant and young child nutrition. The Executive Committee defines conflict of interest as a relationship that may arise:

“in circumstances where there is potential for a secondary interest (a vested interest in the outcome of Member States’ work in the area of public health nutrition) to unduly influence, or where it may be reasonably perceived to unduly influence, either the independence or objectivity of professional judgment or actions regarding a primary interest (related to Member States’ work in the area of public health nutrition)” (A71/23, para.10).

The Executive Committee has developed a tool, described as “a step-by-step decision-making process”, to support member states to prevent and manage such conflicts of interest in the area of nutrition. Member States are invited to assess at each step of the process whether engagement with a non-State actor in the area of nutrition should start, continue, discontinue or be rejected.

The tool consists of six steps as below:

Step 1	The engagement of external actor should support the implementation of member states' policies, technical norms and standards.
Step 2	Member States should perform due diligence and profiling to assess the risks of external actors.
Step 3	Member States should analyze the risk and benefits of the engagement based on assessed impacts.
Step 4	National authority has two options after the assessment of risks and impacts. Those are if benefits exceed risks, national authority should not proceed with the engagement. If benefits are greater than risks, national authority could proceed with the engagement.
Step 5	The next step is to ensure that engagement has achieved the envisioned public health nutrition goals through systematic monitoring and evaluation.
Step 6	And the last step suggests about communicating about the engagement activities and outcomes to relevant audiences to ensure transparency.

PHM's analysis and recommendations

PHM appreciates the initiative of WHO to support Member States in managing the direct influence of transnational companies and external actors in formulating nutrition policies and programs. However, PHM raises four concerns:

First, the tool may facilitate the forging of commercial relations between transnational food corporations and Member States and shape the terms of this engagement. For example, the second step in the tool “to have a clear understanding of the risk profile of the external actor and the engagement” requires transparency on the part of the external actor and significant capacity in MS to analyze the operations of the actor. Commercial actors can claim compliance with the framework and norms set by WHO as their operations are often camouflaged by the establishment of front ‘institutes’ or ‘foundations’. Thus, in practice, the tool could make it harder, not easier, for Member States to ‘say no’ to Big Food. **This risk should be taken into consideration and addressed by institutionalizing the tool as legally binding document and defining operational mechanisms for ensuring adequate financing, accountability and transparency.**

In this regard, PHM supports [The Vision Statement](#) adopted by public interest civil society organizations participating at the Second International Conference on Nutrition (ICN2) which called for: “democratic governance of food and nutrition and for government-led normative and regulatory frameworks ... [to] ensure proper accountability of all actors involved”. Tools such as that described and discussed at the 71st World Health Assembly are a poor substitute for the design and implementation of effective rules and regulations on conflict of interest.

Second, Member States often lack the technical capacity to institute nutrition policies and programs. Consequently, private sector expertise is often sought, through for example, public-private partnerships. However, as detailed in the [The Social Movements Statement on Nutrition](#), released at ICN2, lack of technical capacity further diminishes efforts by Member States to resist efforts by transnational food corporations to influence policy. Providing a tool for assessing conflict of interest is an example of ‘putting the cart before the horse’. **PHM, therefore, urges WHO to assist Member States to build national capacity to assess and mitigate the risk of involvement of external agencies.**

Third, the tool focuses attention of conflict of interest at the national level, but overlooks the very serious problem of conflict of interest at the global level, notably within global public-private partnerships (GPPPs). GPPPs, in particular Scaling up Nutrition (SUN), the Global Alliance for Improved Nutrition (GAIN) and the World Food Programme, play a very influential role in international policy and action around food and nutrition. The participation of transnational corporations and other private sector entities in global policy making around global food systems (often through these GPPPs) is highly problematic given the role of transnational corporations in globalizing trade in agriculture and processed foods and in local production and retail. WHO has a [Partnership policy](#), endorsed in 2010 at the 63rd World Health Assembly (A63/44), which includes a number of criteria “to assess future partnerships and will guide the relationship with the existing formal partnerships”. These include (8(h)):

“Pursuit of the public-health goal takes precedence over the special interests of participants. Risks and responsibilities arising from public–private partnerships need to be identified and managed through development and implementation of safeguards that incorporate considerations of conflicts of interest. The partnership shall have mechanisms to identify and manage conflicts of interest. Whenever commercial, for-profit companies are considered as potential partners, potential conflicts of interest shall be taken into consideration as part of the design and structure of the partnership”.

PHM calls on Member States to develop and adopt a resolution mandating the Secretariat to undertake a review of GPPPs in the food and nutrition field in which WHO participates, against the criteria adopted in WHA63.10.

Lastly, development of nutrition policy and programmes utilizing the proposed tool will be a long process. It is particularly challenging for those Member States that have not yet developed relevant policy or programmes. **A national body should be in place to monitor the progress of this process and analyze the immediate and long term impacts of nutrition policy and programs in the country.** PHM urges WHO to play a proactive role in encouraging and assisting Member States to establish an independent monitoring body with strengthened community participation to track actions further.