

People's Health Movement

Background and Commentary on Items coming before WHA71, May 2018

Introduction

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

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

[GHWatch/WHA71](#) provides links to PHM item commentaries and policy briefs and to WHO Watch statements to the Assembly during the debate.

This document provides a compendium of PHM item commentaries. This version of this document is published 2 May 2018 at which time several Secretariat papers are yet to be published and accordingly the commentaries on those items are not included here.

Feedback welcome: [edit\[at\]phmovement.org](mailto:edit[at]phmovement.org).

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11.1 Draft thirteenth general programme of work, 2019–2023

In focus

The Assembly will review the draft thirteenth global program of work (GPW13, in [A71/4](#)).

The Assembly will consider the draft resolution suggested by the Executive Board (in [EB142.R2](#)).

See Fig 1, p7, for an overview. See Box 3 for an overview of ‘what is new in GPW13; the chief selling points of the GPW from the Secretariat point of view.

As of 15 April [A71/4 Add.1](#) (✚) has not been published. We are not told whether this file contains advice on financial and administrative implications of the proposed resolution or perhaps responds to the Board request (in [EB142.R2](#)) to the DG regarding the impact framework, financial estimates and investment case.

Background

The GPW is the highest level planning document of WHO. This GPW serves several functions:

- it sets out the priorities and principles which will frame the biennial programme budgets which it encompasses;
- it affirms and underpins Dr Tedros's authority as new DG, both differentiating his leadership from that of Dr Chan and offering a newly polished vision which might shore up the confidence of member states and re-inspire WHO staff and public health practitioners globally; and
- (perhaps most importantly) it supports the case for loosening the donor chokehold: lifting the freeze on assessed contributions and untying voluntary contributions.

Previous GPWs have stretched across six years and included three biennia and commenced following the conclusion of the previous GPW. Thus GPW12 notionally covered 2014-19 including the last biennium (18-19). The Programme Budget for 2018-19 was set out in [A70/7](#) and endorsed in [WHA70.5](#).

Accordingly GPW13 would be expected to commence in 2020 and cover the six years (three biennia) from 2020-26. However, the new DG has determined that GPW13 will commence in 2019 and cover the five years from 2019-23 and will inform two programme budgets (20-21 and 22-23). PB18-19 as adopted at WHA70 in May 2017 will remain in place but the DG proposes to redirect funds authorised under PB18-19 to support the strategies outlined in GPW13 to the extent of his authority.

Outstanding work

The draft GPW released in November promised a forthcoming ‘investment case’ to support the GPW. The Board was presented with a ‘financial estimate’ in [EB142/3 Add.2](#). This document includes in paras 11 & 12 references to investment and concludes that “GPW 13 presents a unique return on investment”.

However, the Board made it clear in [EB142.R2](#) that it did not endorse the financial estimate and in [EB142.R2](#) asked the DG to finalise work on financial estimates and investment case prior to WHA71.

[EB142.R2](#) also asks the DG to finalise work on the Impact Framework for WHA71. The new ‘impact and accountability framework’ is described (para 122-128, Fig 6 and Box 8) but in para 128 the Assembly is advised that “Further translation into a detailed plan will be done through the programme budget planning process”.

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

PHM Comment

Old wine in new bottles

There is much to appreciate in the draft GPW although the document is as much marketing spin as strategic plan.

In large degree this draft GPW13 is designed to draw a line under the Dr Chan era and differentiate Dr Tedros from his predecessor, in particular with the references to strategic and organizational *shifts*. This may reflect a judgement that the budget ceiling, ACs freeze and tightly earmarked funds in some way reflected distrust of Dr Chan. Accordingly considerable symbolic distance has been created between the previous regime and the new leadership, not least by the decision to bring the 13th GPW forward by a year. Nevertheless, there is not much of substance in the GPW with which Dr Chan would disagree.

The new packaging is significant. Having only three strategic priorities suggests a newly focused leadership and a willingness to prioritise which are common demands from donor member states. In fact the three priorities are very broad and it is hard to identify existing programs or activities that would be excluded by these three priorities. The emphasis on WHO's normative role suggests a willingness to restrict WHO to its domain of competitive advantage which is clearly designed to reassure donors who are apprehensive about a more activist WHO (eg support for a sugar tax). However, there is still lots of scope for contentious issues to arise given the breadth of this GPW and the commitment to the full hand of SDGs.

Financial crisis

Clearly this document is intended as an important resource in the funding dialogue. The last para of the whole document is significant:

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 un earmark their contributions. This is a sign of trust and enables management to deliver. Increasing assessed contributions would also give WHO greater independence.

It will be unfortunate if, as has happened before, despite such appeals most of the donors continue to highly earmark their donations. Un earmarking as a sign of trust will not look good if, at the next funding dialogue, the donors again refuse to untie their donations.

In May 2017 PB16-17 was funded to around 90% of budgeted expenditure ([A70/6](#)), a \$500m shortfall. The emergency fund was seriously under-subscribed.

PB18-19 ([A70/7](#)) envisages an annual budget of around \$2,200 million. This is around 30% of the annual budget of US CDC; 4% of Pfizer's turnover; 3% of Unilever's turnover; and around 10% of Big Pharma's annual advertising in the US. It is simply not enough for WHO to properly fulfil its responsibilities in global health.

The proper response to the funding crisis should be an increase in assessed contributions. Dr Chan proposed a 10% increase to EB140 (Jan 2017) but following opposition from certain member states this was reduced to 3% for PB18-19. [A70/INF./2](#) provides a more detailed rationale for the 3% increase. See [WHA70-PSRA3](#) for the WHA discussion of the 3% increase.

The purpose and effect of the freeze on ACs is continued dependence on donor funding and continued donor control over WHO's program of work. See [PHM comment on donor control in WHA70 Item 11.2 on PB18-19](#). An essential part of the donor control strategy is tight earmarking of almost all donor funding. Virtually all WHO's programmatic expenditure is funded through donor funds. Strategies which are endorsed by the Assembly but which donors do not like, do not get implemented.

The draft GPW is largely silent on WHO's financial crisis and eschews any reference to the donor chokehold; to the contrary it promises that resource mobilisation will involve a joint effort between member states and the Secretariat:

The focus on demonstrating impact will strengthen the case for investing resources over and above the assessed contributions. WHO will seek good-quality, multi-year funding with greater flexibility. Value-for-money will be shown by evidence of cost-effectiveness and evidence of impact on the most vulnerable populations. WHO will also advocate for the larger envelope of global health funding that is required to achieve the SDGs. (Box 3)

Clearly the new leadership hopes that the draft GPW (with its focus on country level work, and UHC, emergencies and the SDGs) will help to shore up the confidence of member states and perhaps build support for lifting the freeze on assessed contributions and untying voluntary contributions.

There is no reference in the draft GPW to the financing dialogue through which the Secretariat meets with WHO's donors to try to persuade them to fund the various programs and initiatives endorsed by the Assembly. The funding dialogue effectively institutionalises donor control of WHO's operational budget.

The donor chokehold over WHO's finances is the most critical challenge to be addressed in GPW13. The only practical solution is a substantial increase in the level of assessed contributions.

PHM calls on member states to recognise the importance of WHO's work and the human cost of the continuing donor chokehold and to commit to a schedule of increasing assessed contributions by 5-10% in each of the next three biennia.

Operational priorities.

The opposition to Dr Chan's call for a 10% increase in ACs in Jan 2017 was accompanied by dark warnings about priority setting and fiscal discipline. The Secretariat responded with the 'Value for money' strategy (elaborated in [A70/INF.6](#)) which foreshadowed a further round of cuts and 'efficiency savings'. [WHA70.5](#) requests the DG ... "to control costs and seek efficiencies, and to submit regular reports with detailed information on savings and efficiencies as well as an estimation of savings achieved."

The draft GPW seeks to navigate between the imperative of a forward looking inspirational document and the pressures to prioritise. The GPW gets around this problem by adopting an all encompassing understanding of UHC (including pharmaceuticals policy, emergency preparedness and support for the SDGs) and by defaulting to the priorities established for the Agenda 2030 in the shape of the 'health related SDGs'.

WHO, under Dr Chan has emphasised 'financial protection' as the defining quality of UHC. While financial protection and rapid reduction in out-of-pocket expenses is a necessary condition for universalisation of secure access to comprehensive health care services, it needs to be accompanied by significant scaling up and continued support for delivery of healthcare through public provisioning. The GPW is entirely silent about the role and importance of public services in healthcare.

PHM appreciates the acknowledgement that UHC needs to be based on primary health care (PHC) but this needs further elaboration given the ambiguity regarding WHO's position on selective primary health care vis a vis comprehensive health care. Several of WHO's large donors would reduce "PHC" to the delivery of a 'basic benefit package'. Para 32 of the present draft promises that "WHO will work with partners to design the package of essential services ..."

We appreciate the emphasis on workforce development in the draft GPW (although the reference to "the global mobility and migration of health personnel" (para 42) is quite obscure. WHO must continue its work on the regulation of health worker migration, especially as regards to responsibilities and obligations of importing countries in the global North.

The GPW is silent about the impact of contemporary 'free trade' agreements on health and is quite vague in referring to threats to healthcare and to population health associated with market power.

The GPW appears to promote a charity model of health development through its several references to 'the vulnerable'. It is 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.

Placing countries at the centre

The draft GPW promises to place countries squarely at the centre of its work (para 84) with training and recruitment initiatives directed to an upgrading of the role of WHO representatives, a new 'operating model' (from para 107), further investment in country relevant information and enhanced country cooperation strategies. This commitment echos similar commitments from previous directors-general but it has proved very difficult to achieve .

In this context PHM appreciates the references to country level policy dialogue but urges that the Secretariat gives closer attention to civil society engagement in such dialogue. Civil society mobilisation is an important driver of health development, locally, nationally and globally and the caution of country offices in engaging with local civil society has been a significant weakness in WHO's country work.

PHM also appreciates the commitment to 'drive impact in every country'. The draft promises a 'differentiated approach based on capacity and vulnerability' which means varying emphases on policy dialogue, strategic support, technical assistance and service delivery depending on the capacity and vulnerabilities of particular countries. However, "WHO will strengthen its role in driving policy dialogue in all Member States (para 87)".

Certainly there is an urgent need for a more challenging and robust debate regarding global health policies and priorities, including in the rich countries. However, the reasons this function has been weak in the past are related to the accountability structures within which WHO Representatives (WRs) and regional directors (RDs) work, both of whom are constrained by the sensitivities of, and sanctions available to, member states through the regional committees. There are no structural proposals offered which might empower WRs and RDs to engage in challenging and robust policy dialogue with member states or to engage with civil society organisations (CSOs) in developing such dialogue.

From outputs to outcomes and impacts

PHM appreciates the commitment in the draft GPW to more meaningful metrics for assessing the outcomes and impacts of WHO's work.

WHO has been under continuing pressure to cost and measure outputs and outcomes. Often such urgings are embedded in a narrative of alleged inefficiencies, opacities and lack of accountability; a narrative which is designed to justify the freeze on assessed contributions. WHO should not be driven by such self-serving arguments.

The draft GPW promises to 'measure impacts to be accountable and manage for results'. In the complex adaptive global system in which WHO works, linear schemes of outputs, outcomes and impacts are overly simplistic, notwithstanding the recognition of the 'combined contribution of WHO, member states and partners'. Health development strategies must engage with a swirl of contemporaneous dynamics, economic, political, cultural and environmental. A 'theory of change' which recognised this complexity would also recognise the powerful role played by civil society organisations and changing climate of community sentiment.

However, moving the emphasis from measuring 'outputs' to 'outcomes and impacts' brings to the fore the question of attribution: who contributed what to measured outcomes? Responding to this the draft GPW comments (para 106):

Progress depends on many joint actions by WHO and its partners – governments, United Nations entities, civil society or the private sector. For that reason, it is less important to attribute advances to specific parties than it is to achieve impact and build confidence in the leadership and contribution of WHO to that shared success. WHO's contribution is detailed in GPW 13 and will be further detailed in the impact and accountability framework.

It appears that the attribution question will be managed through greater and more systematic use of qualitative narratives including case studies, supported by quantitative data where appropriate. It will be important to separate this process from the public relations blitz foreshadowed in para 113.

One of the most critical steps in the results chain in PB18-19 ([A70/7](#)) are the so-called 'deliverables', which have been largely ignored in the rush to measurement. Systematic reflection on the quality, efficiency and impact of 'deliverables' is critical in strengthening organisational learning across WHO. The 'deliverables' get to the heart of what the staff and programmes of WHO do on the ground, day by day. Accountability to the governing bodies should not get in the way of organic action research and action learning at the workplace.

The reference to 'partners' in the above quote is open to different interpretations. WHO's partners have variously included intergovernmental organisations (such as UNICEF, UNDP and the World Bank), large philanthropies (such as Gates and Rockefeller), international business associations (eg the IFPMA), corporations (eg vaccine manufacturers), and various civil society organisations (including public interest CSOs such as IBFAN, HAI). In this context two issues stand out: first, the continuing pressure on WHO to extend the use of the 'multi-stakeholder partnership' model of program design (with a view to giving corporate 'partners' a 'seat at the table'); and second, the very cautious approach hitherto adopted by WHO country offices to collaboration with local civil society organisations.

Some of the 'multi-stakeholder partnerships' involving WHO working with private sector entities includes the notorious IMPACT initiative with big pharma ([Shashikant 2010](#)) and SUN and REACH in the nutrition arena ([Valente 2015](#)). The draft GPW comments that:

WHO must act in concert with partners, including civil society, research institutions and the private sector, and in close alignment with the United Nations system, in order to avoid duplication, using its Framework of Engagement with Non-State Actors.

PHM urges the new leadership to treat with caution the continuing pressure to adopt the 'multi-stakeholder partnership' model of program design especially where it involves inviting the foxes into the chicken shed. The framework for engagement with non-state actors (FENSA, [WHA69.10](#)) provides principles and protocols for the management of potential conflicts of interest, including those associated with 'multi-stakeholder partnerships'. It remains to be seen how effective these protocols will prove to be. (See [Legge 2016](#) for more detail and references.)

The FENSA is focused solely on decisions taken within the Secretariat and does not address the accountability of member states. There have been notorious lapses in member state accountability including the IMPACT controversy; the psoriasis resolution proposed by Panama in the EB133 (May 2013) and adopted in May 2014 in WHA67.9 ([PHM comment here](#)); and the Italian intervention on behalf of the sugar/chocolate industry in EB137 (May 2015) ([PHM comment here](#)). A core weakness of WHO is the lack of domestic accountability of member states for their contribution to WHO's work and their implementation of agreed policy directions.

Of comparable importance is the lack of accountability of regional committees and regional directors, an issue which has been commented upon repeatedly by the UN's Joint Inspection Unit ([JIU/REP/93/2](#), [JIU/REP/2001/5](#), [JIU/REP/2012/6](#)). Hopefully the new GPW will signal further steps towards 'alignment' and 'harmonisation' across regions and strengthened regional accountability.

Multisectoral action

PHM applauds the recognition of the need for more systematic engagement by WHO in multisectoral action across all of the SDGs (paras 79-80). A stronger foreign affairs capacity in the WHO secretariat would greatly facilitate WHO's engagement in progressing the various 'non-health' SDGs (goals for which other intergovernmental agencies have coordination responsibility), including their health related aspects.

A more structured approach to intersectoral engagement should also prioritise intensive industrial animal husbandry (with implications for climate change, antibiotic resistance and nurturing pandemics); land grabbing (with implications for nutrition, deforestation and livelihoods); tax avoidance and tax competition associated with foreign investment; chemicals control; and air pollution; all 'non-health' SDGs with significant health implications.

PHM appreciates the emphasis on access to medicines as part of UHC. However, several of the most critical issues are either ignored or referred to in the most indirect way. These include:

- support for countries to preserve and utilise TRIPS flexibilities in accordance with [A59.26](#);
- proposals for delinking the price of new medicines from the cost of R&D through an R&D treaty as recommended by the [Commission on Innovation, Intellectual Property and Public Health](#);
- strengthened medicines regulation, including action on substandard and falsified medicines (see most recently the annex to [A70/23](#));
- mandatory collection and publication of vaccine prices; and
- mandatory registration of clinical trials and full publication of clinical trial datasets.

The absence in the GPW of any direct reference to IP barriers to access appears to reflect the continuing pressure from 'Big Pharma', including via their countries of origin, to prevent WHO from addressing IP related issues.

Action around trade, NCDs and the social determinants of health has been consistently underfunded in the last three biennia reflecting the donors' opposition to any kind of regulatory response to these challenges. Meanwhile, however, under the aegis of the Human Rights Council, proposals for a global treaty directed to regulating transnational corporations and other business enterprises is under development. Official consideration of this initiative is carried in the [open-ended intergovernmental working group](#) but there is a network of public interest civil society organisations campaigning around curbing corporate impunity (see <https://www.stopcorporateimpunity.org/>). WHO should be engaging in this debate. The effective regulation of TNCs is not going to be achieved easily but it will be critical to addressing the challenges associated with NCDs, SDH, pharmaceuticals and many other issues which are central to WHO's mandate.

In this context the references (in the draft GPW) to 'focusing global public goods [normative functions] on impact' are intriguing, given the explicit inclusion under WHO's normative functions of binding agreements as well as guidelines and technical advice. One of the reasons the rich countries are so determined to maintain the donor chokehold over WHO is the potential significance of the Organisation's treaty making powers. Previous debates around the strategic use of WHO's treaty making powers have focused on the marketing of breastmilk substitutes and the 'ethical' promotion of pharmaceuticals. In the present era the potential application of these powers to food labelling, sugar and fat taxes and an R&D treaty underlie the determination of the TNCs and their nation state sponsors to maintain the donor chokehold.

Summary

PHM is fully committed to the Constitution of the WHO, appreciates the forward looking character of the draft GPW and stands ready to work with WHO under its new leadership in a renewed effort to achieve Health for All. PHM urges Member States to lift the freeze, lift the budget ceiling and untie their donations in order to enable the new leadership to realise the promises in this workplan.

11.2 Public health preparedness and response

In focus

Two major policy areas are subject to discussion under this item; the first dealing with WHO's Health Emergencies Program (WHE) and the second with the implementation of the International Health Regulations (2005) ([IHRs](#)).

WHE Programme

[A71/5](#) conveys the fourth report of the Independent Oversight and Advisory Committee for the WHO Health Emergencies Programme (IOAC WHE). The IOAC report is generally positive in regarding performance and implementation progress of the WHE. However, it expresses concerns regarding:

- communications, coordination and management processes,
- the workings of the Incident Management System (IMS),
- human resource planning,
- financing the WHE programme, including core budget, appeals and the contingency fund (CFE),
- procurement and supply chain management (speed of delivery);
- security, staff protection, prevention of, and response to, sexual exploitation and abuse,
- external coordination,
- IHR capacities monitoring and compliance regarding 'additional health measures'.

There may be debate regarding the IOAC's recommendation for greater support for country-level resource mobilisation in the light of the repeated calls for coordinated organization wide resource mobilisation.

More about the IOAC [here](#).

[A71/6](#) provides an overview of WHO's work in health emergencies, focusing in particular upon:

- WHO's response and coordination in severe large scale emergencies,
- cholera prevention and management (there may be a resolution on cholera control),
- research and development in the context of emergencies, in particular, rapid vaccine development.

The [WHE webpage](#) provides more recent updates, including on the Ebola outbreak in DRC.

IHRs

[A71/7](#) convey's the DG's annual report on the implementation of the [IHRs](#). The report provides:

- event related information (public health events as recorded in the event management system),
- progress in strengthening of national core capacities,
- procedures under the IHRs, and
- Secretariat support to states parties for implementation of the IHRs.

[A71/8](#) conveys the draft Five Year Global Strategic Plan to Improve Public Health Preparedness and Response (strengthening core capacities under the IHRs) accompanied by a draft resolution forwarded from EB142 ([EB142\(1\)](#)).

Background

WHE

For a summary of the prehistory of the Health Emergencies Programme see [PHM Background Note for Item 12.1](#) at WHA70.

See [A69/30](#) for the framework for WHO's WHE Programme as adopted in [WHA69\(9\)](#). See Emergency Response Framework ([ERF, 2017](#)) for a more detailed and practical account of how the WHE is supposed to work.

On cholera see [Global Taskforce on Cholera Control](#). See also [WHO Media Release](#) of 7 May 2018 on 'Largest cholera vaccine drive in history to target spike in outbreaks'.

On the R&D Blueprint see: [A70/10](#) from May 2017.

IHRs

See brief history of the IHRs in [A69/21](#)

Note the history of the saga of core capacities in [Appendix 2](#) to the draft Five Year Global Strategic Plan.

Note the summary of [country capacity](#) in WHO's Global Health Observatory and the IHR [Monitoring Framework](#).

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

See [Tracker links](#) to previous discussions of WHE and IHRs.

PHM Comment

WHO's Health Emergency Program

The need for emergency preparedness, response and recovery is huge. The humanitarian crises described in [A71/6](#) and in more detail on the [emergencies webpage](#) are dreadful.

The fourth report of the IOAC (in [A71/5](#)) confirms that the health emergencies reform was well conceived and to this point appears to have been implemented well, notwithstanding the issues identified for further attention by the Committee.

PHM appreciates the progress which has been made in the implementation (and operations) of the programme. PHM appreciates the constructive role being played by the IOAC.

PHM questions whether the barriers to speed and flexibility noted by the IOAC reflect the tight compliance requirements and internal controls put in place in the Secretariat in recent years under continuing pressure from the donors. PHM questions whether the somewhat obscure reference by the IOAC to WHO's geographic mobility policy reflects concern regarding the implications of this policy on the staffing of the WHE.

PHM notes the serious under-funding of both the Contingency Fund (\$18m out of \$100 target, see [A71/29 6.1.b](#)) and the core budget for WHE (see Fig 1 in [A71/30](#)). WHO took a lot of criticism over its response to the Ebola crisis in 2014 but PHM reminds member states that when the previous DG sought to create a contingencies fund for emergencies (as recommended by the [Review Committee for H1N1](#) in 2011 and in 2012 ([EB130/5 Add.7](#))) she was refused funding support by the donors. (See [DG response in M7 at EB130](#).)

PHM notes the degree to which the work of WHO's Health Emergencies Programme is a consequence of geopolitical crimes driving the crises in the Eastern Mediterranean and economic injustices (corruption, tax evasion, unfair trade rules, etc) in the African region which have contributed to humanitarian crises in that region. It seems that the public health principle of understanding upstream determinants does not apply in relation to health emergencies.

Cholera: vaccines, prompt quality primary health care, water supply and sanitation

The [Cholera Road Map](#) recognises the importance of decent primary health care and improved water supply, sanitation and hygiene (WASH) as well as vaccination in treating and preventing cholera.

However, it is evident from the DRC costing exercise (in the Road Map document) that the cost of vaccination is much less than the cost of health systems strengthening and WASH infrastructure. The Road Map calls for donors to commit to the Road Map. And so they should.

But the long term solution to cholera lies with economic development of the poor countries so that they are in a position to mobilise domestic financing. The barriers here lie in the failed promises of the Washington Consensus. The dynamics of contemporary neoliberal globalisation continue to drive the transfer of value from poor to rich and from Global South to Global North.

R&D blueprint to prevent epidemics

The R&D blueprint ([A70/10](#) and [A71/6](#)) is a very constructive initiative. The processes for prioritisation and the development of target product profiles are very promising.

Financing arrangements will be critical but appear to be still quite uncertain. We note

- the establishment of the Global Coordination Mechanism,
- the MOU with [Coalition for Epidemic Preparedness Innovations \(CEPI\)](#) (a public private partnership to finance and coordinate the development of new vaccines) and
- the proposed MOU with [Global Research Collaboration for Infectious Disease Preparedness \(GloPID R\)](#) (a coalition of research funding agencies).

Details regarding the role and accountability of the Global Coordination Mechanism appear to be still under discussion. The mechanism must be governed by the Secretariat and Member States, and not by non-state actors.

There is no explicit mention in the documents reviewed of the principle of delinking the price of products from the cost of research as developed under the Consultative Expert Working Group on Research and Development: Finance and Coordination. It is not clear how intellectual property issues will be managed under the R&D blueprint. Such arrangements need to ensure that products developed with public funds under the Blueprint cannot be licensed under patent and then sold at market prices. (See [KEI/MSF comments on PaxVax](#) controversy.)

It is not clear how the principles of equitable access and benefit sharing (as developed under the PIP Framework) will operate under the R&D blueprint. It is essential that the principles of the Nagoya Protocol are adhered to.

Draft five-year global strategic plan

The core capacities specified in [Annex 1](#) to the IHRs for Surveillance and Response and for Points of Entry make sense. While national authorities would all want to see that such capacities were in place, many countries are finding it very challenging.

Among the 129 countries responding to the 2016 questionnaire ([here](#)) significant shortfalls were evident including an overall implementation status of only 65% for points of entry and only 61% for human resources. The country profiles reported on the [IHR monitoring framework website](#) provide more detail. It is noteworthy that 65 states parties did not respond to the questionnaire. Presumably these countries are facing more serious challenges.

It is evident that simply giving countries a deadline by which to implement the required capacities is unrealistic. The review committee appointed following the H1N1 pandemic in 2009 ([H1N1 report 2011](#))

was critical of the failure of many member states to establish the required core capacities and a series of deadlines were set (and passed) for full implementation by all countries. This criticism was reiterated by the review committee appointed following the West African Ebola outbreak in 2014 ([Ebola report 2016](#)). There was a certain degree of finger pointing during governing body discussions of IHR implementation during this period.

The draft global strategic plan marks a welcome departure from such finger pointing in that it includes much more emphasis on assisting those countries which face particular challenges in implementation.

Nonetheless, PHM has reservations about the 'principle' of Domestic Financing (see Appendix 1 of [A71/8](#)). Principle 10 argues that for "long-term sustainability, the ... financing of core capacities ... should be supported to the extent possible from domestic resources".

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

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

PHM appreciates that the draft global strategic plan goes beyond simply addressing core capacities in several respects:

- recognition of close links between core capacity development and more generic health systems strengthening;
- the integration of capacity assessment and development within the Health Emergencies Programme, including within the purview of the IOAC;
- the provision of ongoing support to countries including developing the role and significance of the national IHR focal points; disseminating evidence-based guidelines regarding preparedness and response;
- adoption of a more systematic approach to states parties implementing 'additional measures' (beyond those authorised under the IHRs).

The proposed 'conceptual framework' on the links between IHR capacity building and health system strengthening will be very useful. Whilst the synergies between these two fields is self-evident in general terms, a more detailed analysis of how health system strengthening might contribute to IHR core capacity development will be helpful.

The monitoring framework developed in 2010 was based on a self-assessment tool which involved voluntary responses to a questionnaire regarding the core capacities. The review committee, appointed to advise on Second Extensions for IHR Implementation, which reported in 2015 ([A68/22 Add.1](#)), recommended moving beyond relying solely on self-assessment "to approaches that combine self-evaluation, peer review and voluntary external evaluations involving a combination of domestic and independent experts".

In accordance with this recommendation the revised [monitoring and evaluation framework](#), adopted at WHA69 in 2016, is based on an annual self-assessment ([current questionnaire here](#)) and three voluntary 'peer review' tools: the joint external evaluation ([current tool here](#)), and an 'after-action review' and /or simulation exercise.

PHM welcomes the new orientation of the draft global strategic plan, in particular: the emphasis on health systems strengthening, the commitment to assist with funds mobilisation for countries facing

difficulties, the systematic approach to 'additional measures' and the more developmental approach to continually strengthening preparedness and response capacity.

However, the move towards (voluntary) external evaluations of core capacities has raised concerns for some developing countries. WHO does not have a strong tradition of member state accountability with independent monitoring so the introduction of such mechanisms, in relation to an issue where implementation shortfalls have been particularly common in developing countries, may be seen as discriminatory. Nevertheless if the joint external evaluations are managed sensitively it will contribute to a more developmental approach to capacity development and perhaps point the way to strengthening member state accountability in relation to other commitments.

In this regard PHM welcomes the inclusion of 'community involvement' among the guiding principles on which the draft global strategy is based. The ultimate accountability of member states must be to their people.

11.3 Polio transition and post-certification

In focus

In focus under this item are: organisational transformations necessitated by the closure in 2019 of the Global Polio Eradication Initiative and funding shortfalls associated with the closure of the GPEI and possible funding options.

The report by the Director-General ([A71/9](#)) presents the key elements of a draft five year strategic action plan for polio transition. The plan supports the implementation of the GPEI post-certification strategy (contain, protect, detect and respond), and addresses the mainstreaming of polio-funded capacities and assets, under the aegis of GPW13 referring to its support for UHC (immunisation) and IHRs (surveillance and laboratories, etc).

The mandate for this report lies in decision [WHA70\(9\)](#) ([link](#) to papers and discussion); reaffirmed in decision [EB142\(2\)](#) ([link](#) to papers and discussion).

The development of the draft strategic action plan has been based on close analysis of national polio transition developed in 12/16 polio transition priority countries (summarised in [Annex 2 of EB142/11](#)).

Three key objectives are outlined:

- **sustaining a polio-free world after eradication of polio virus** (deals with 'polio essential functions' defined in accordance with the GPEI's [Polio Post-certification Strategy](#)); how polio essential functions are to be integrated within mainstream WHO programs (especially immunisation and emergencies) *and* in national health sector programs (supported by WHO as necessary, including financial support);
- **strengthening immunization systems, including surveillance for vaccine-preventable diseases**, in order to achieve the goals of WHO's Global Vaccine Action Plan; (refers to polio-funded assets and capacities which have helped to support immunisation programs, but which will be no longer be funded through the GPEI); to be integrated within mainstream WHO programs and national programs but will need replacement financing (domestic and external, including through WHO); links to GPW and commitment to UHC emphasised;
- **strengthening emergency preparedness, detection and response capacity** in countries in order to fully implement the International Health Regulations (2005); addressing the existing shortfalls regarding IHR capacities plus the need to integrate polio-essential and polio-funded surveillance and laboratory services into WHO's emergency program, and into corresponding national programs, with appropriate funding.

The Figure on page 6 of [A71/9](#) presents an overview of the plan framed in terms of the results chain. See also Table 4 (page 15) summarising the proposed monitoring and evaluation framework for the plan.

Estimated costs of sustaining essential polio functions through 2019-2023 are presented for polio priority countries in Table 1 (more detail in Annex 1) followed by an exploration of financing options in Table 2. Table 2 highlights the huge shortfall in domestic funding and the huge financing gap facing WHO.

Tables 1 & 2 are explicitly labelled as encompassing polio-essential functions and by implication excluding polio-funded capacities and assets which are critical to immunisation and surveillance but are not polio-essential.

There are no estimates of the shortfalls with respect to the future funding of polio funded capacities and assets at country and WHO level. Para 66 of [A71/9](#) refers to the 'business case' developed by the African and Eastern Mediterranean offices regarding financing needs associated with polio funded support to immunisation programs. Para 19 of [A71/9](#) notes that WHO's Emergency Programme's 'country business model' will include estimates of funding needs associated with polio-funded preparedness and surveillance

functions. Para 66 also notes that WHO is developing an investment case for vaccine-preventable disease surveillance.

[A71/9](#) also provides an update on the numbers of polio funded staff in head office and the regions and outlines expectations for attrition, arrangements for transfers into mainstream programs and estimates of WHO indemnity liabilities.

[A71/9](#) also sets out the proposed monitoring and evaluation framework for polio transition (see Table 4 on page 15).

Finally the paper sets out 'the way forward' (from para 58), listing key strategic decisions yet to be finalised; pointing towards further planning challenges; highlighting the need to support countries; and to address the concerns of staff members.

It appears that the Assembly is not invited to review [the Post-Certification Strategy](#) (PCS) which was discussed by the GPEI Oversight Board in December 2017 and noted by EB142 in EB142(2). According to a summary presentation from [August 2017](#) the revised PCS was intended to be presented to WHA71 but it is not included among the papers circulated for WHA71.

There is no reference in A71/9 to the possibility of funding streams currently flowing to the GPEI being redirected to WHO. Undoubtedly the Secretariat will be pursuing this possibility.

Background

The challenges associated with transition planning were outlined in [A70/14 Add.1](#).

In decision [WHA70\(9\)](#) the Assembly:

- acknowledged the need to strategically manage the 'ramp-down' of the Global Polio Eradication Initiative (GPEI);
- expressed concern regarding the dependence of many WHO programmes on GPEI funding in the face of the 'ramp-down';
- noted the need for transition planning as outlined in [A70/14 Add.1](#);
- requested the DG to present a draft strategic action plan on polio transition for consideration by EB142 for forwarding to WHA71;
- requested the DG to report to WHA71 on efforts to mobilise funding so as to transfer the funding of programmes currently supported by the GPEI into the programme budget.

These requests were reaffirmed in EB142(2).

See the [GPEI Transition Planning](#) webpage for links to a range of resources regarding transition planning.

See also ['Transition planning for after polio eradication' by Rutter et al](#) in the Journal of Infectious Diseases (Nov 2017):

The Global Polio Eradication Initiative (GPEI) has been in operation since 1988, now spends \$1 billion annually, and operates through thousands of staff and millions of volunteers in dozens of countries. It has brought polio to the brink of eradication. After eradication is achieved, what should happen to the substantial assets, capabilities, and lessons of the GPEI? To answer this question, an extensive process of transition planning is underway. There is an absolute need to maintain and mainstream some of the functions, to keep the world polio-free. There is also considerable risk—and, if seized, substantial opportunity—for other health programs and priorities. And critical lessons have been learned that can be used to address other health priorities. Planning has started in the 16 countries where GPEI's footprint is the greatest and in the program's 5 core agencies. Even though poliovirus transmission has not yet been stopped globally, this planning process is gaining momentum, and some plans are taking early shape. This is a complex area of work—with difficult technical, financial, and political elements. There is no significant precedent. There is forward motion and a willingness on many sides to understand and address the risks and to explore the opportunities. Very

substantial investments have been made, over 30 years, to eradicate a human pathogen from the world for the second time ever. Transition planning represents a serious intent to responsibly bring the world's largest global health effort to a close and to protect and build upon the investment in this effort, where appropriate, to benefit other national and global priorities. Further detailed technical work is now needed, supported by broad and engaged debate, for this undertaking to achieve its full potential.

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

PHM Comment

PHM supports the directions outlined in A71/9 and urges member states to support the Secretariat.

PHM urges member states to commit to an increase in assessed contributions sufficient to cover the huge budget shortfall associated with the closure of the GPEI.

Failing this PHM urges donor states increase their voluntary contributions so as to ensure full funding of the transition plan.

11.4 Health, environment and climate change

In focus

Several separate issues are up for consideration under this item:

- health, environment and climate change,
- climate change in small island developing states, and
- human health and biodiversity.

Health, environment and climate change

The report [A71/10](#):

- summarises the continuing disease burden associated with environmental degradation and global warming;
- reviews the current status of the public health response to environmental risks including global warming;
- calls for transformational change for more effective upstream action in accordance with the SDGs;
- calls for WHO to play a stronger role and for a renewed mandate for such a role;
- calls for continuing development of research, evaluation and evidence-based policy options;
- calls for integration of action on climate and environment into the core functions of public health.

In response to an earlier version of this report the Executive Board (in [EB142\(5\)](#)) requested the DG to develop, a draft comprehensive global strategy on health, environment and climate change, to be considered by WHA72 in May 2019, through EB144 in January 2019.

It is likely that [A71/10](#) will be discussed and then simply noted.

Climate change in small island developing states

The Executive Board (EB142 in Jan 2018) considered an earlier version of [A71/10](#) and in [EB142\(5\)](#), after noting the several references to the health effects of climate change in small island developing states, requested the DG to prepare a draft action plan to address the health effects of climate change in small island developing states, and to submit the draft action plan for consideration by WHA72 in May 2019, through EB144 in January 2019.

In adopting this decision the Board also took note of the inclusion [in GPW13 of Platform 5](#) in which the focus is on addressing health effects of climate change in small island developing States.

Human health and biodiversity

In [EB142\(5\)](#) the Board requested the DG:

to prepare a report on actions taken on the interlinkages between human health and biodiversity for consideration by the Seventy-first World Health Assembly in order to prepare WHO's contribution to the fourteenth meeting of the Conference of the Parties of the Convention of Biological Diversity [November 2018].

[A71/11](#) responds to this request and includes:

- context and policy mandate,
- biodiversity and health links,
- collaborative activities,
- ways forward.

The Assembly is invited to note the report and provide further guidance.

Background

Health, environment and climate change

[A71/10](#) provides an interim overview but the main debates around the proposed comprehensive strategy will take place in EB144 and WHA72 in 2019.

WHO's first [Climate and Health Workplan 2008-2013](#) was adopted in [EB124.R5](#). Following the first Health and Climate Change Conference (reported in [EB136/16](#)), a revised plan (2014-2019) was adopted at EB136 based on [EB136/16](#). EB139 (May 2016) asked the Secretariat to prepare a further revision of the [2014-19 plan](#) taking into account the four strategic priorities proposed in [EB139/6](#).

WHO has an excellent [web site](#) on climate change including a useful [directory of web resources](#) including links to websites and reports of various academic and not-for-profit organisations.

[“Preventing disease through healthy environments: A global assessment of the burden of disease from environmental risks”](#) by Prüss-Ustün and colleagues was published by WHO in 2016. Provides very useful insights into environmental contributions to disease burden.

The 5th Report of the IPCC (2014) includes the report of Working Group 2 on *Impacts, Adaptation, and Vulnerability*, which includes a section on *Human Health, Well-Being, and Security* which includes three relevant chapters:

11. [Human health: impacts, adaptation, and co-benefits](#) - 3.7MB
12. [Human security](#) - 1.3MB
13. [Livelihoods and poverty](#) - 2.3MB

The [Synthesis Report](#) integrates the findings of all three main working groups (on the physics, adaptation etc, and mitigation).

See also:

- [Second Global Conference on Health and Climate \(July 2016\) - Outcomes](#), and
- [Ministerial Declaration on Health, Environment and Climate Change \(Nov 2016\)](#).

Small island states

Dr Tedros identified climate change as one of his top five priorities in his campaign for election ([here](#)). A focus on the impact of climate change on small island developing states was part of the first draft of GPW13 considered at EBSS4 in November 2017. It is conceivable that the special needs of small island states featured in Dr Tedros's campaigning for election.

The special needs of small island states will be discussed by the Assembly but the main debates around the proposed draft action plan under '[Platform 5](#)' will take place in EB144 and WHA72 in 2019.

A key reference point in this discussion is [the special initiative to address climate change impact on health in small island states](#) was launched at the UN Climate Change Conference (COP23) in November 2017. The initiative involves WHO collaborating with the UN Climate Change Secretariat and the Fijian Presidency of COP23. The initiative has four main goals:

- First, to amplify the voices of health leaders in Small Island Developing States, so they have more impact at home and internationally.
- Second, to gather the evidence to support the business case for investment in climate change and health.

- Third, to promote policies that improve preparedness and prevention, including "climate proof" health systems.
- Fourth, to triple the levels of international financial support to climate and health in small island developing states.

See also the [Secretariat page on the WHO UNFCCC Climate and Health Country Profile Project](#) which aims to raise awareness of the health impacts of climate change, support evidence-based decision making to strengthen the climate resilience of health systems, and promote actions that improve health while reducing carbon emissions. The profiles provide country-specific estimates of current and future climate hazards and the expected burden of climate change on human health, identify opportunities for health co-benefits from climate mitigation actions, and track current policy responses at national level.

Human health and biodiversity

The report before the Assembly ([A71/11](#)) is directed to developing WHO's contribution to the 14th Conference of the Parties (COP14) to the CBD in Nov 2018.

In EB142(5) the Secretariat was asked to give consideration to the State of Knowledge Review (prepared by WHO and CBD and published in 2015) in preparing A71/11. [Full report here](#). [Key messages here](#).

See also the [draft decision](#) prepared for CBD COP14 by the CBD's technical advisory body.

The [Convention on Biological Diversity \(CBD\)](#) was signed in 1992 and came into force in Dec 1993 (196 parties not including the US). The Convention has two main protocols: Cartagena Protocol on biosafety (171 parties) and the Nagoya Protocol on access to genetic resources and fair and equitable benefit sharing (104 parties).

See the [CBD page on Health and Biodiversity](#) and also the CBD page for the [Interagency Liaison Group on Biodiversity and Health](#) (with links to the [report of the first meeting of the Group](#)).

Previous discussions

See [Tracker links](#) to various EB/WHA discussions of climate change, various environmental issues and health.

PHM Comment

Health, environment and climate change

PHM appreciates the decision to develop an Action Plan and Global Strategy. The DG is applauded for his commitment to action on global warming and other issues of environmental destabilisation.

PHM particularly appreciates:

- the emphasis on the urgency of these issues and the need for transformative change;
- the focus on the SDGs;
- 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.

Addressing these issues is a large and complex task. There are several different 'entry points':

- surveying modifiable environmental hazards and estimating associated disease burden;
- identifying priority intersectoral issues;
- giving due weight to distributional issues (gender, age, countries, etc);
- identifying priority intersectoral issues;
- addressing regulatory and governance issues, including rolling back neoliberalism; and
- strengthening the capacity of the health sector to engage in intersectoral collaboration at all levels.

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. [Preventing disease through healthy environments](#) is a very useful resource in this respect.

Distributional issues

Disease burden and exposures are not uniformly distributed.

- low and middle income countries bear a disproportionate burden
- low income and marginalised groups in all societies bear a disproportionate burden
- women and girls face disproportionate exposures in certain respects
- certain occupational groups face disproportionate exposures (eg farm labourers, ship breakers)
- children are particularly vulnerable to certain exposures

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 terms of whole-of-government decision making.

From this perspective some of the key (overlapping) intersectoral priorities are:

- cities: urban planning, transport, housing, **water supply and sanitation**;
- urban **transport policy**: fossil versus solar power, public versus private transport, vehicle emissions, road safety;
- energy: pricing and taxing **carbon emissions**; also housing standards (including **cooking fuels**), transport policy;
- occupational exposures; and
- food systems, including sustainable agriculture and water policies.

Regulatory and governance capacity

The necessary regulatory and governance capacity, particularly at the global level, is generally lacking. The agenda for strengthening such includes:

- control of carbon emissions, including through carbon pricing and taxing;
- trade policy including in particular ISDS provisions in trade agreements designed to protect transnational corporations from regulation;
- regulation of corporations;
- regulation of specific industries;
- environmental assessment and planning tools;
- effective engagement in public policy debate and opinion shaping;
- engaging municipal governments;
- resources to support green structural change; and

- research, monitoring and evaluation.

Political economy of social and economic development: neoliberal globalisation

A particular and over-riding challenge in terms of governance capacity is the need to roll back neoliberal globalisation.

Global economic instabilities and threats associated with the neoliberal ascendancy are:

- driving rich countries to impose global trade, investment and finance policies which prevent Third World development, including immigration policies which skim the educated and wealthy from the 'developing' world;
- driving transnational corporations to intensify the exploitation of workers and to externalise production costs to the environment;
- driving a race to the bottom in terms of national regulatory capacity and taxation revenues (public expenditure capacity); and
- are increasing the risk of economic collapse associated with debt and deflation.

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

Health sector issues

Effective engagement in intersectoral collaboration around environmental health is a big job. The health sector needs significant capacity building:

- strengthening environmental health capacity at all levels
- strengthening health sector capacity to engage effectively in whole of government policy analysis, development, implementation, and monitoring at all levels,
- including in particular strengthening the role of primary health care in policy advocacy and community engagement around environmental issues

Small island states

The Executive Board (in [EB142\(5\)](#)) has requested the DG to prepare a draft action plan to address the health effects of climate change in small island developing states for consideration in 2019.

Presumably the DG will follow the lines he outlined in his [speech](#) at the launch of the special initiative to address climate change impact on health in small island developing states: global advocacy around climate change mitigation, fund raising and increased financial support for preparedness, prevention, protection and resilience.

This is an admirable initiative.

Human health and biodiversity

The brief given to the Secretariat under this sub-item is quite restricted, "to prepare a report on actions taken on the interlinkages". This it has done (in [A71/11](#)): describing the interlinkages, reporting on a number of collaborative activities.

The report (A71/11) also outlines a set of actions planned for the Secretariat under the joint work program of work 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](#) lists many links between biodiversity and human health. One set of links are where biodiversity and the integrity of ecosystems support human health directly, including issues such as:

- food security,
- access to clean water,
- pandemic risk,
- toxic chemicals (eg bees; hormonal disrupters),
- destruction of human ecosystems (especially impacting on indigenous peoples),
- degradation of human microbiome,
- medicines derived from various life forms

Biodiversity is also a health issue because many of the environmental trends which are threatening biodiversity are also associated with risks to human health, for example,

- industrial agriculture (pandemic risk, antibiotic resistance, unsustainable water use),
- overfishing (food security),
- deforestation (pandemic risk),

Biodiversity is also a health issue because of health sector interventions which can impact on biodiversity, eg pharmaceuticals (antibiotics) in hospital waste discharge.

PHM urges member states to authorise 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.

As well as the initiatives mentioned in A71/11, COP13 Decision XIII/6 ([here](#)) and its Annex provide a useful checklist of actions and policy directions.

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

In focus

The Assembly is invited, in EB142(3), to request the Director-General to elaborate a road map report outlining the programming of WHO's work on access to medicines and vaccines, including activities, actions and deliverables for the period 2019–2023; and to submit that road map report to WHA72 in May 2019, through EB144 in Jan 2019.

The most contentious issue complicating this proposed decision is the report of the [Secretary-General's High Level Panel on Access to Medicines \(HLP\)](#) and in particular its recommendations directed to delinking the funding of research and development from profits based on IP-protected monopoly pricing. At WHA70 the US led the opposition to consideration of the HLP report supported by Japan, while Colombia, Brazil, India and others argued that there was much in that report for WHO to consider.

[A71/12](#) notes that WHO is already engaged in a wide 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 summarises relevant work currently undertaken by the Secretariat.

The Assembly's deliberation regarding [EB142\(3\)](#) will be informed by [A71/12](#) which presents a series of possible actions which WHO could undertake to overcome the barriers to affordable reliable access to safe, effective and appropriately used medicines and vaccines. The actions listed in the Executive Summary are based on an exhaustive survey of existing policies and programs and a detailed whole-of-supply-chain analysis of a range of barriers to affordable access to safe, effective and appropriately used medicines and vaccines (see Annex to [A71/12](#)). These barriers are discussed under 11 headings:

- (a) Political will and governance
- (b) Workforce
- (c) Needs-based research, development and innovation
- (d) Public health-oriented intellectual property and trade policies
- (e) Regulation to ensure quality, safety and efficacy
- (f) Strategic and sustainable local production
- (g) Pricing policies
- (h) Procurement and supply chain management
- (i) Appropriate prescribing, dispensing and use
- (j) Monitoring of pharmaceutical systems
- (k) Collaboration

From the surveys presented under each of these headings a total of 33 'key considerations' are drawn and on the basis of this list of 'key considerations' a series of possible actions for the Secretariat are identified in the main body of the report; actions for which a mandate already exists through previous resolutions (listed in Appendix 1 to the Annex). These are then prioritised in terms of impact, complexity and cost with three packages (in addition to work already underway - paras 8 and 10):

1. high impact, low complexity and low cost (para 7);
2. high impact but more costly and more complex (para 9)
3. highly complex and expensive (para 11)

The actions listed in the Executive Summary could form the basis for the proposed 'road map' although with two sticking points: first, the prevarication around delinking and the proposed R&D treaty; and second, the implied prioritisation based on 'cost and complexity'. Access to medicine activists will be looking to WHO to endorse the principle of delinking (as recommended in the HLP report) and to prioritise by impact (rather than targeting the 'low hanging fruit').

[A71/12](#) also provides a brief report on the implementation of Resolution [WHA69.25](#) from 2016 which commissioned work on a global notification system addressing ‘supply side’ and ‘demand side’ shortages (see [A70/20](#) for a more detailed analysis of ‘shortages’).

Background

Access to medicines has been a recurring theme in WHO governing body discussions for several decades. The pre-history of WHO’s consideration of access to medicines and the role of IP is summarised [here](#). See also [GHW3 \(D4\)](#) on the pharmaceutical industry (2011).

The issues have moved through a number of different forums over the last several decades:

- UNGA 1974 and the New International Economic Order (see [Drahos, 2002](#));
- International Anticounterfeiting Coalition, formed in 1979 (by TNCs led by Pfizer), seeks to shift discussion of IP regulation from WIPO to trade negotiations;
- WTO 1994 and the TRIPS agreement;
- WHA resolutions [WHA49.14](#) in 1996 and [WHA52.19](#) in 1999 regarding TRIPS and medicines;
- 1997-2001 the Treatment Action Campaign in South Africa (and beyond);
- WTO 2001 and the Doha Statement on Public Health
- WHO ([WHA56.27](#)) and the Commission into Intellectual Property Rights, Innovation and Public Health, appointed 2004 [reported](#) in 2006; (more [here](#))
- the IGWG, EWG and CEWG reports (more [here](#));
- the UNDP sponsored [Global Commission on HIV and the Law](#) (2010-2012);
- the [Secretary General’s High Level Panel on Access to Medicines](#) (appointed Nov 2015 and published in Sept 2016); and
- the Human Rights Council Resolution on Access to Medicines ([A/HRC/32/L.23/Rev.1](#)), [30 June 2016](#).

This present item commenced life with a report ([EB138/41](#)) to the EB in Jan 2016, prepared “in response to requests from Member States” on global shortages of medicines and suggesting a global approach to deal with ‘supply side’ and ‘demand side’ failure. Just two months before this EB meeting the Secretary General of the UN had appointed his High-level Panel on Access to Medicines.

At WHA69 (May 2016), following discussion of global shortages (informed by [A69/42](#); debate at [B5](#) and [B7](#)) [WHA69.25](#) was adopted. [A69/42](#) was essentially the same as EB138/41 except that the options for a more systemic approach were revised and it now included harmonised definitions of “stock outs” and “shortages” and standards for a global notification system. [A69/42](#) also referred to the conclusions of a [technical consultation on shortages and stock outs](#) held in December 2015 (and supported by the international pharmacists association, FIP). The prominent involvement of South Africa in this meeting was significant given the work undertaken there on stock outs (see [Stop Stockouts](#)). The Assembly adopted [WHA69.25](#) which focused on the ‘management of shortages’ and broadly looked towards a global medicines shortages notification scheme.

Meanwhile the [High Level Panel on Access to Medicines](#) was finishing its work and its report was published in September 2016. The report provides a broad sweep of recommendations (see [Executive Summary](#)) relating to:

- TRIPS flexibilities and TRIPS-plus provisions;
- publicly funded research;
- new incentives for research;
- stronger accountability of governments;
- a stronger role for the UN SG and UNGA;
- greater disclosure and transparency by corporations;
- complete transparency regarding clinical trials;

- publicly accessible databases regarding patents and related data regarding medicines and vaccines.

In the lead up to EB140 in Jan 2017 the officers of the Board elected not to include the HLP report on the EB agenda. This was controversial and following debate the Board agreed to discuss it. In the subsequent debate (at [PSR11](#)) the US expressed strong criticisms of the HLP report (supported by Switzerland and Japan) whereas Colombia, Thailand, Algeria, India, Brazil, Iran, South Africa and Venezuela all spoke in favour of the HLP being discussed. The outcome of this debate was that the Board decided to add reference to 'access to medicines' to the WHA70 agenda item on 'shortages'.

In May 2017 at WHA70 there was further sparring around the HLP report. Again the US led the opposition to consideration of the HLP report supported by Japan, while Colombia, Brazil, India and others argued that there was much in that report for WHO to consider. It was decided to defer substantive consideration of Shortages and Access to EB142.

In January 2018, the Executive Board noted an earlier version of [A71/12](#) and adopted decision [EB142\(3\)](#) in which it recommended that WHA71 adopt the draft decision committing to a 'road map'.

The 'actions' listed in A71/12 could form the basis for a road map, in conjunction with programs of work already underway and described in A71/12. When the draft road map comes to EB144 and WHA72 the debates around delinking, transparency, prioritisation, funding and other contentious issues will be resumed.

See [Tracker links](#) to previous documents, debates and decisions in relation to shortages and access to medicines, including previous PHM commentaries.

PHM Comment

PHM urges member states to support the proposed decision. However, the decision as it presently stands is just a shell without content. Member states need to give the Secretariat a clear mandate in relation to the draft road map including endorsing delinkage, prioritisation on the basis of impact rather than cost and complexity, and to commit to fully funding the program. The actions listed in paras 7-11 of [WHA71/12](#) should be endorsed as key elements of the proposed road map. As A71/12 makes clear, all of the 'possible actions' have been mandated by previous resolutions of the governing bodies as summarised in Appendix 1.

The arguments for delinking need to be articulated clearly. Countries which aspire to universal health cover must recognise that this includes affordable secure access to effective, safe and appropriately used medicines. Countries which commit to public funding of health care must recognise that patent based R&D is producing extremely high prices including for essential medicines; prices which are for most countries incompatible with universal health cover. In such circumstances rich people will pay privately and poor people will be denied access to such medicines.

The second argument for delinking concerns the neglect by the pharmaceutical industry of R&D for antibiotic development, for pandemic risks and for diseases which selectively affect poor people because of limited profit expectations.

Looming over these specific policy questions is the deliberate underfunding of WHO, which prevents it from fully implementing the resolutions listed in Appendix 1, *and* which is imposed with the explicit intention of preventing WHO from fully implementing resolutions which Big Pharma opposes.

Policies such as are not being fully implemented because of the ongoing funding crisis facing WHO.

Appendix 3 seeks to demonstrate that most of those HLP recommendations, which lie within the mandate of WHO (eg regulatory strengthening, price transparency, ethical promotion), are already

being addressed in the operations of the Secretariat. While this is useful in undercutting the demonisation of the HLP report by the US it is quite misleading. In fact, the investment in many of the 'WHO activities' listed in Appendix 3 is more token than substantive because work in these areas is grossly under-funded as a consequence of the budget ceiling, the ACs freeze, tight earmarking and the refusal of donors to adequately support these activities.

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

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

The 2006 Trade and health resolution ([WHA59.26](#)) provides a particularly egregious example of the determination of big pharma and its member state representatives to prevent WHO from implementing the mandates given by its governing bodies. This resolution which was adopted in May 2006, authorised the Secretariat to provide advice to countries on how to fully utilise the flexibilities included in the TRIPS Agreement. For 10 years there has been a page on the WHO website which announces that *"To implement this resolution, WHO is developing a diagnostic tool and companion workbook that will guide national policymakers building public policies and strategies related to trade and health."*

It was not until 2015 that the 'companion workbook' was published (['Trade and health: towards building a national strategy'](#)). The workbook is a very useful edited collection of short papers by experts in various aspects of trade and health. In his preface Dr Mirza states:

This publication was initiated some years ago as part of a programme to support WHO Member States to systematically assess their trade and health situation. The project was originally conceived as two parts: the first, a background document on key issues in trade and health and the second, an assessment tool to facilitate the development of national strategies on issues at the trade and health interface. We are now pleased to make available online this background document.

In other words the 'tool' has yet to be delivered. Very few of the references in the document are later than 2008. It appears that it has been sitting unpublished for perhaps seven years.

This document is cited in Appendix 3 as evidence that WHO is somehow addressing the needs identified by the HLP. It would be better to say, how it is not addressing the needs identified by the HLP. At best it is token rather than substantive.

PHM's criticism is not directed at the hard working staff of the cluster who are given huge responsibilities but minimal funds and from time to time face active political interference. Neither is our criticism directed at the Secretariat staff who have cited this document as demonstrating that the recommendations of the HLP correspond to the mandate which has been given to the Secretariat by the governing bodies.

Rather we cite this case as illustrating how the 'possible actions' identified in [WHA71/12](#) must be contextualised in terms of the donor chokehold over WHO and the determination of big pharma's nation state representatives to prevent WHO from taking effective action on affordable, reliable access to safe, effective and appropriately used medicines and vaccines.

PHM calls upon member states to recognise how their ability to deliver universal health coverage (including medicines) has been held hostage in defence of big pharma. PHM calls upon member states to demand and enable WHO to ramp up its engagement in the 'health-proofing' of future trade/investment agreements and the 'trade-proofing' of future national health regulations.

Lift the freeze, now!

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

In focus

[EB142\(4\)](#) is a draft decision to implement those recommendations of the Overall Program Review (OPR) which are encompassed by the GSPOA and to consider further those recommendations of the OPR which are not 'emanating from' the GSPOA.

The proposed decision would authorise the Director-General to develop and enact an implementation plan encompassing the recommendations addressed to the Secretariat 'consistent with the global strategy and plan of action on public health, innovation and intellectual property'.

In Document [A71/13](#) the Director-General sets out the Priority Actions identified in the final report of the Overall Programme Review (OPR, full report [here](#)) of the Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property (GSPOA, [here](#)).

The report presents recommendations on the way forward for the next stage of implementation of the Global Strategy and Plan of Action, with respect to the addition, enhancement and conclusion of relevant elements and actions.

The Secretariat estimates the cost of implementing all the recommendations of the Overall Programme Review across the four years 2019-22 as \$31.5m for the full set of recommendations and \$16.3m for the high priority actions. The proposed expenditure is not covered within existing resources.

Background

Genealogy

See [PHM comment on Item 13.4 at WHA70](#) for a summary of the prehistory of the GSPOA including the origins and [report](#) of the 2006 Commission on IP, innovation and Public Health and the subsequent debates which led to the [GSPOA](#). This prehistory is also usefully reviewed in the [report](#) of the Overall Programme Review.

The PHM comment at WHA70 also reviews the commissioning of the 'comprehensive evaluation' and the 'overall programme review'. The Comment:

- explains the decision ([WHA68.18](#)) to undertake the evaluation before the review;
- notes the Executive Summary of the Evaluation in [A70/21](#); full report [here](#);
- notes the terms of reference for the Overall Programme Review in [EB140\(8\)](#) and
- notes that the outcomes of the Review will be presented to WHA71 through EB142 (see also [WHO webpage for Overall Programme Review](#)).

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

See [Tracker links](#) to previous documents, debates and decisions regarding the follow up of the Consultative Expert Working Group on Research and Development: Financing and Coordination (CEWG).

The Overall Programme Review in a nutshell

From the [report of the Review](#):

Our review has confirmed that while there have been some positive developments since 2008, the fundamental concerns that justified the development of the GSPA-PHI remain.

Research and development is still not sufficiently directed at health products for diseases that mainly affect developing countries. Resources devoted to R&D on these diseases have not sustainably increased. There is evidence of progress for some diseases but for many diseases we still lack the tools and financial resources necessary if we are, for example, to meet the health targets set in the Sustainable Development Goals.

The GSPA-PHI is an ambitious framework, but its 108 action points are too many and lacking in precision. It has proved difficult to monitor progress. Too little effort has been devoted by all stakeholders to pursuing its implementation. The low awareness of the GSPA-PHI revealed by WHO's own evaluation is symptomatic of its lack of significant overall impact.

The focus of the Review is on:

- institutional mechanisms to identify R&D gaps and priorities;
- improved collaboration, coordination in R&D and transparency in R&D costs;
- strengthening R&D capacity;
- promoting technology transfer;
- encouraging the use of TRIPS flexibilities, greater transparency in patenting and licensing,
- expanding patent pooling and
- a variety of measures to promote delivery of health care and access to health products.

The 17 high-priority actions include:

- Member States to establish sustainable financing for the [Global Observatory on Health Research and Development](#) and the Expert Committee on Health Research and Development.
- Member States to support the WHO Secretariat in promoting transparency in, and understanding of, the costs of research and development.
- The WHO Secretariat to establish an information-sharing mechanism to promote collaboration and coordination in research and development linked to the Expert Committee on Health Research and Development and the Global Observatory on Health Research and Development.
- The WHO Secretariat and Member States to develop and support collaboration programmes between internationally recognized centres for research and development and relevant institutions in developing countries to enable those countries to enhance their capacity across the research and development pipeline
- The WHO Secretariat to identify mechanisms to increase health technology transfer in the context of the Technology Facilitation Mechanism established by the Sustainable Development Goals.
- The WHO Secretariat, in collaboration with other international organizations working in intellectual property, to advocate for the development of national legislation to fully reflect the flexibilities provided in the TRIPS Agreement, including those recognized in the Doha Declaration on the TRIPS Agreement and Public Health and in Articles 27, 30 (including the research exception and “Bolar” provision), 31 and 31bis of the TRIPS Agreement.
- 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.
- Member States to encourage the implementation of schemes that partially or wholly delink product prices from research and development costs, including actions recommended by the Consultative Expert Working Group on Research and Development

The Review proposes 33 measurable, action- and time specific indicators. Responsibility for specific actions is assigned to WHO and Member States.

PHM Comment

The recommendations of the Overall Programme Review largely endorse and recapitulate the commitments of the GSPOA and the recommendations of the CEWG although with fewer actions and a restricted focus on the WHO Secretariat and the member-states.

PHM supports the full adoption and funding of the recommendations of the Review. Many of the regulatory and transparency reforms are achievable without huge funding commitments. We urge a particular focus on the expansion of pharmaceutical R&D in middle income countries and the facilitation of technology transfer to support this.

Significantly the Secretariat notes that funding for the implementation of the Review's recommendations is not provided for in the current programme budget.

The [report](#) of the Overall Programme Review recognises WHO's funding crisis:

WHO has also proposed a pooled fund along lines suggested by the CEWG. However, the funding required for the demonstration projects has not materialized; and the pooled fund has yet to attract funding. (p13)

In spite of some successes, the number of new products for diseases that affect mainly developing countries still represents a small proportion of all new products coming on the market. Furthermore, funding for R&D on these diseases has not increased sustainably: in 2015, total funding (except for the Ebola virus and related diseases) was at its lowest since 2007. (p14)

PHM calls on member states to lift WHO's budget ceiling, to lift the freeze on assessed contributions and cease the earmarking of member state donor contributions.

The OPR acknowledges the 'vehement opposition' of the rich countries to a global fund for R&D:

Whether or not delinkage is pursued, increasing R&D on diseases that mainly affect developing countries will require funding additional to that from the price paid for the product, in the absence of a profitable market. Thus, one issue in the negotiations was whether a global fund for R&D on diseases that principally affect developing countries should be established. The countries that would be expected to be the main contributors to such a fund vehemently opposed this proposal ... (p27)

Nevertheless, the OPR urges Member States to encourage the implementation of schemes that partially or wholly delink product prices from research and development costs. This recommendation is likely to be strenuously opposed by the member states for big pharma.

The OPR notes that despite the GSPOA recommendations regarding the full use of TRIPS flexibilities and technology transfer the US, Europe and Japan have been driving trade agreements including TRIPS plus provisions which preclude the use of those flexibilities.

PHM calls upon governments and civil society globally to resist the drive for TRIPS plus provisions in trade agreements and to ensure that developing country governments preserve access to TRIPS flexibilities.

11.7 Preparation for the third High-level Meeting of the UNGA on the Prevention and Control of NCDs, to be held in 2018

In focus

In [WHA70.11](#) the Assembly requested the DG submit, to the Seventy-first World Health Assembly in 2018, through the Executive Board (EB142), a report on the preparation for the third High-level Meeting of the General Assembly (HLM of UNGAss) on the Prevention and Control of Non-communicable Diseases, to be held in September 2018.

The requested report, in [A71/14](#), includes:

- an overview of the magnitude and distribution of the burden of disease attributable to NCDs, showing a widening gap between high income countries and low and middle income countries; and demonstrating that the world is not on track to achieve SDG target 3.4 (reduce by one third premature mortality from NCDs);
- an overview of member state implementation of national commitments showing a substantial shortfall in implementation (Table 4); see updated Appendix 3 of Global Action Plan at Annex 1 of [A70/27](#)
- a list of obstacles to national implementation including lack of political leadership, weak health systems, weak policy, program and regulatory capabilities, inadequate development finance for NCD action and industry interference (Table 5);
- a commitment to review international experience in the control of NCDs with a view to identifying lessons learned and successful approaches to implementing the 'best buys' of Appendix 3 (Table 6);
- a recognition that a lack of consensus among member states regarding such obstacles is a critical barrier to progress (para 16);
- an outline of the process through which the Outcome statement from the Third High Level Meeting is to be developed and a brief review of key resources which will be drawn upon in developing that statement;
- a commitment to publishing an investment case for the prevention and control of NCDs on 20 May 2018 (para 28);
- a report on action undertaken by the WHO Secretariat on 10 assignments arising from the Second High Level meeting in 2014 (Table 7); and
- four annexes reporting on
 - progress in implementing the Global Action Plan (Annex 1);
 - progress made by the Global Coordination Mechanism (Annex 2);
 - progress in implementing WHA70.12 on cancer prevention and control (Annex 3); and
 - progress made by the UN Interagency Taskforce (Annex 4).

In addition [A71/14 Add.1](#) reports on a preliminary evaluation of WHO's Global Coordination Mechanism. The report finds that the GCM is relevant and useful but of limited effectiveness. One set of limitations involve coordination, engagement and communication.

The report recommends the development of a medium term strategic plan including a clear engagement strategy, improved coordination and communication.

Background

Major landmarks in the development of WHO's work on NCDs include:

- WHO's first global strategy adopted in May 2000 ([WHA53.17](#));
- the 2008 Action Plan (2008-2013) ([WHA61.14](#));
- the Moscow Ministerial Meeting and Statement (May 2011, [WHA64.11](#));

- the Political Declaration of the UNGAss (September 2011, [EB130/6](#));
- the Global Action Plan 2013-2020 ([WHA66.10](#)) including the global monitoring framework and the nine voluntary global targets; (report in Annex 1 of [A71/14](#));
- the 'limited set of action plan indicators' for the WHO Global Action Plan (Annex 4 to [A67/14](#));
- the establishment of the Global Coordination Mechanism (see para 8 of the Annex to [A67/14 Add.1](#)) and the proposed work plan for the mechanism (at para 5 of [A67/14 Add.3 Rev.1](#)); see the [GCM/NCD](#) webpage and also the [working group reports](#); (report in Annex 2 of [A71/14](#); preliminary evaluation in [A71/14 Add.1](#))
- the establishment of the United Nations Interagency Task Force (para 17 of [A67/14](#)); see [IATF](#) webpage; (report in Annex 4 of [A71/14](#));
- the [Outcome document](#) of the 2nd HLM of the UNGAss on NCDs in 2014 (see summary reports in paras 10 & 11 of [A71/14](#)).

See overview of the pre-history of WHO's NCD Program in [PHM's WHA70 commentary](#)

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

PHM Comment

PHM has commented previously on the Global Action Plan and the various structures, consultations, documents, goals, indicators involved. See [Tracker links to previous governing body discussions](#) including PHM comments as well as official documents, debates and decisions.

[A71/14](#) is a substantive report including detail across a number of important areas. In summary the material included in [A71/14](#) and [A71/14 Add.1](#) demonstrate:

- a lack of progress in reducing the burden of NCDs and widening inequalities between the high income countries and the low and middle income countries with respect to disease burden;
- significant barriers to progress and the lack of consensus among the member states regarding whether and how to address those barriers;
- the ambivalence of powerful member states in relation to the role of corporate interests in driving the NCDs epidemic and interfering with attempts to prevent and control;
 - see in particular the contributions of the US and Italy to the debate around the revised Appendix 3 at WHA70; (see [BPSR4, page 14](#); [BPSR5, p5](#) and [BPSR7, p7](#))
 - note the contrast between the uber voluntarism of the Global Action Plan for NCDs and the obligations and sanctions associated with trade agreements;
 - note the lack of any reference to trade in the work plans of the GCM or the IATF (including, in particular, IP issues and ISDS);
- the need for the OHCHR (and in particular the WG on a TNCs treaty) to be brought into the [Interagency Taskforce](#) (noting the recently finalised cooperation agreement between WHO and the OHCHR);
- the significance of health system issues in the prevention and control of NCDs including access to pharmaceuticals;
- the gross underfunding of WHO's work on NCDs (and the link to the donor chokehold);
- the need for tax reform, including protecting L&MICs from corporate extortion (promises and threats around foreign investment) as conditions for sufficient public revenue for health system strengthening;
- the need for increased attention to defining, analysing and strategising around the social, political, economic and cultural determination of NCDs incidence as well as to behavioural risk factors.

It is apparent that high income countries are making some progress in the prevention and control of NCDs. This reflects strong health systems; strong policy, program and regulatory capacity; supported by strong professional and community support for effective action.

Conversely many low and middle income countries are making little or no progress in the prevention and control of NCDs. This reflects weak health systems, weak policy, program and regulatory capacity; and a relatively weak professional and community constituency for action.

Health system strengthening (including single payer public financing, strong public sector provision, full implementation of primary health care principles and equitable access to medicines and vaccines) is a critical prerequisite for both prevention and treatment of NCDs. Effective policy formation, program implementation and regulatory capacity all depend on strong health systems and public health research. Advocacy and public education in the high income countries has been in part driven by health professionals including researchers.

The WHO Secretariat, including all three levels, has the tools to contribute substantially to health system strengthening; to capacity building in policy development, program implementation and regulatory strengthening; and to support constituency building. The WHO Secretariat has the tools to greatly strengthen intersectoral awareness around NCDs at the national level and across the UN system. However, the budget provision for WHO's NCDs work is ridiculously small and to a serious degree not funded. This is a direct result of the freeze on assessed contributions, the budget ceiling, and the insistence of donors on tight earmarking of voluntary donations. The underfunding of WHO's work on NCDs is a deliberate strategy on the part of the rich countries to limit WHO's influence in this arena.

The donor restrictions on WHO's work are directly linked to the corporate interests which drive the epidemic and which continually interfere with WHO's work. Both the [June 2017 workshop](#) and the report of the IATF (in Annex 4 to [A71/14](#)) highlight the role of industry in driving the epidemic and obstructing WHO's work.

The most stark example in recent times of member states acting on behalf of corporate interests against health objectives was the Italian intervention in relation to WHO's dietary guidelines (see relevant links [here](#)).

However, the US has led the way in limiting WHO's work on NCDs and in defending the freedom of corporate interests to purvey health damaging products and to obstruct regulatory initiatives. Within the WHO the US strategy has been to insist on qualifying all regulatory proposals as 'voluntary' or 'as appropriate'. However, beyond the WHO, in the field of trade policy, the role of the US in supporting tobacco, sugary beverages and other nutritional hazards has been much more muscular and in this they have been supported by other rich countries.

Most of the rich countries have in fact implemented regulatory strategies to control tobacco use and in some cases to limit diet related hazards. Their refusal to adequately fund WHO's work in NCDs and the neglect of NCDs in their own bilateral development assistance is all the more hypocritical in the light of their own efforts to prevent and control NCDs domestically.

PHM calls upon WHO member states to:

- lift the freeze, untie voluntary donations, lift the budget ceiling and properly fund WHO's work on NCDs;
- mandate a closer engagement with the Office of the High Commissioner for Human Rights in the development of a treaty to regulate transnational corporations;
- increased bilateral and multilateral development assistance finance including an order of magnitude increase in assistance for health system strengthening, and policy, program implementation and regulatory capacity building in relation to the NCDs pandemic.

11.8 Preparation for a high-level meeting of the UNGA on ending TB

In focus

In [resolution 71/159](#) (2016), the United Nations General Assembly noted the plans for the [Moscow Ministerial Conference on TB](#) (Moscow, 16 and 17 November 2017) and decided to hold a high-level meeting on tuberculosis in 2018 and requested the Secretary-General to make preparations in collaboration with WHO and Member States.

Document [A71/15](#) provides background information, including reference to [WHO's End TB Strategy](#), and an overview of actions taken by WHO by way of preparation for the high-level UN GA meeting on TB in 2018.

The Assembly is invited to adopt the resolution (still not finalised) contained in [EB142.R3](#) which

- urges member states to support preparation for the high level meeting of the UNGA and to implement the commitments in the [Moscow Declaration to End TB](#) which was adopted at the November 2017 Moscow Ministerial Conference;
- calls on all and sundry to implement and support the Moscow Declaration;
- requests the DG to advance the Declaration in various ways.

In addition to recommending a draft resolution for the Assembly to consider [EB142.R3](#) also asks the DG to develop a 'draft multisectoral accountability framework to accelerate progress to end tuberculosis' as recommended in the Moscow Declaration

[A71/16](#) sets out a time table for the development of the accountability framework requested.

[A71/16 Add.1](#) (NYP as of 13 May) conveys the draft framework.

Background

The policy resources developed for the Nov 2017 Moscow conference on TB are linked [here](#). See in particular the [Policy Briefs](#) and the [Moscow Declaration](#).

See [Tracker links](#) to previous governing body discussions of *tuberculosis*.

PHM Comment

[A71/15](#) describes the purpose of the planned High Level UNGA discussion as 'to galvanize the political commitment needed to step up the battle against tuberculosis and help the world and individual countries accelerate progress on the path to ending the epidemic'. This is an important goal and the proposed options and modalities described make sense in this context.

It appears (from para 5) that the G20 discussion in July 2017 may have been informed by the notion of 'global health security' (and the threat to the rich world of MDR and XDR) rather than health as a human right.

PHM affirms that healthy living environments, access to decent health care and management of AMR are human rights issues and should not be overshadowed by the so-called global health security agenda.

12.1 Global snakebite burden

In focus

In [EB142.R4](#) the Assembly is invited to adopt a resolution which:

- affirms the significance of snakebite envenoming as a neglected tropical disease associated with a significant disease burden;
- urges Member States to undertake a range of programmatic initiatives directed to assessing and better managing snakebite burden;
- requests the Secretariat to provide further leadership on this issue through coordination, technical support, collaboration and capacity building.

Document [A71/17](#) provides a useful background to the resolution on the:

- morbidity, disability and mortality due to snakebite envenoming;
- treatment and rehabilitation for snakebite envenoming; and
- WHO's response to snakebite envenoming.

Background

[Health Action International](#) in association with the [Global Snake Bite Initiative](#) have played a major role in encouraging and supporting WHO bringing the issue of snake bite to the attention of the governing bodies.

See also [Williams et al \(2010\) on the Global Snake Bite Initiative](#) in The Lancet in 2010.

PHM Comment

PHM recognises the magnitude of snakebite envenoming and urges member states to support the draft resolution and ensure adequate funding to the Secretariat to enable it to fully implement the proposed list of initiatives.

Every year, poisoning from snakebites accounts for as many as 138 000 deaths and 400 000 cases of lasting disability; in over 2 million more people, it provokes serious illness.

Overwhelmingly the burden of morbidity and mortality related to snakebites is felt by the poorest and most marginalized in the affected regions. Access to treatment following snakebites is often out of the reach of a majority of those affected.

We urge MS to streamline their response to the problem of snakebite by formulating and supporting plans for building capacity for manufacture of safe, good quality and effective antivenoms.

Any intervention regarding snakebites also needs to focus on strengthening primary health care structures and capacity building of health workers, at all levels of care and importantly at the primary level. Health worker training is recognised in the draft resolution but there is no mention of the health system dimension, in particular, the need for accountable, properly funded and supported primary health care services. This could be addressed by adding a new preambulatory paragraph as new PP8:

Recognising universal access to accountable, adequately funded and supported primary health care services is a prerequisite for ensuring early diagnosis and treatment;

The lack of adequate research on the issue of snakebite and the development and manufacture of antivenoms indicates that this is yet another example of the failure of a market driven R&D system.

12.2 Physical activity for health

In focus

In [EB142.R5](#) the Assembly is invited to adopt a draft resolution on a Global Action Plan on Physical Activity 2018-2030. The draft resolution:

- affirms the importance of physical activity;
- recalls previous declarations and resolutions dealing with physical activity;
- endorses the proposed Global Action Plan ([here](#) in full; summarised in [A71/18](#));
- urges member states and invites relevant partners and stakeholders;
- adopts voluntary global targets;
- requests the Secretariat to implement the plan including finalising indicators for monitoring and evaluation, and producing a global status report.

Document [A71/18](#) summarises the current situation, summarises the proposed Global Action Plan and briefly outlines the role of the Secretariat in implementation.

Background

This item was originally proposed (by Thailand and Bhutan) for consideration at EB140 but was deferred to EB142 with the understanding that the Secretariat would prepare a report and draft action plan on physical activity for consideration at EB142 and forwarding to WHA71.

Previous governing body discussions of physical activity include:

- Global Strategy on Diet, Physical Activity and Health in 2004 (see [A57/9](#) and [WHA57.17](#))
- [Global Recommendations on Physical Activity and Health](#) (from 2010)
- Global Action Plan on Prevention and Control of Noncommunicable Diseases (2013–2020) (endorsed in [WHA66.10](#))

See also the WHO [Factsheet on Physical activity](#).

See also the report of the [WHO Commission on the Social Determinants of Health](#) (especially Chapter 6 on Urban settings) and the report of the Knowledge Network on Urban Settings for the Commission ([here](#)).

PHM Comment

Physical inactivity is a risk factor for heart disease, obesity/ overweight and diabetes.

PHM appreciates the decision to develop a global action plan on physical activity and recognises that the present draft includes some very good ideas.

We particularly appreciate the recognition (in Annex 1 of the full draft plan) of the links to the SDGs, in particular, SDG12 (Responsible production and consumption) and SDG13 (Climate action).

Physical activity is facilitated by infrastructure (neighborhood, sporting and recreational amenity, transport options), lifestyle (time, work requirements), cultural values (exercise is good, communal opportunities for activity), and social capital (engagement, relationships, confidence, power).

Thus a comprehensive approach to encouraging physical activity should include:

- urban infrastructure (walkability, cyclability, sporting, recreation, transport, safety, beauty);
- social and economic conditions which leave space in people's lives for recreation, walking, participation;
- support for social participation which includes opportunities for physical activity;
- more equitable, inclusive societies in which people know they belong and are valued;

- social marketing directed at stronger cultural valuing of physical activity.

The draft action plan includes actions around:

- urban planning, residential development (and redevelopment);
- urban transport policy;
- workplace relations;
- support for community organisations, including facilities for physical activity; and
- social marketing in support of all of the above policies *and* directed to a stronger cultural valuing of physical activity.

PHM has two substantive criticisms of the global action plan as presented:

- there is no recognition in the plan of the need to curb the influence of industry sectors whose interests may run counter to creating activity friendly urban settings; and
- while the particular barriers faced by many marginalised communities are recognised, the plan seeks to address these through targeted strategies rather than committing to reducing the inequalities and exclusions which underpin those barriers.

Managing corporate opposition and interference

However, there is no recognition in the draft plan of the corporate interests or the contested nature of many of the development initiatives discussed, especially the corporate interests behind private motorised transport, developer-driven urban planning and mega-shopping centres which assume and require private motor transport.

While [A71/18](#) speaks explicitly about industry opposition and industry interference in the context of NCDs generally there is no discussion in the current draft of the physical activity plan of the comparable challenges in creating urban settings which support physical activity.

There are powerful groups (corporations, industries, classes) in many societies whose interests run counter to the policy principles outlined above, including for example the removal of fossil fuel subsidies. This raises the question as to where the political drive might come from to progress the implementation of this program. This involves, first, building a health-oriented constituency to promote physical activity (in particular linking PHC and public health interests) and, second, strengthening the alliances with those social and political constituencies which are already working in various ways towards more active environments (local councils, labour unions, sporting and recreation organisations, etc).

Social exclusion and marginalisation

Social exclusion and marginalisation is commonly associated with activity-unfriendly physical environments, activity-difficult lifestyles, and reduced self-worth / self-efficacy which can sap motivation. All of these can mitigate against physical activity.

The special barriers facing poorer people and marginalised communities are recognised in the draft plan but the strategies adopted are almost entirely about creating special programs that “increase the opportunities for physical activity in the least active groups” (Action 3.5). Under proposed actions for member states:

Support the development and implementation of programmes using a community-led approach to promoting physical activity in disadvantaged, marginalised or stigmatized, and indigenous communities and populations, including those with mental or physical disabilities.

There may be a role for such programmes but the plan should also address inequality, exclusion and marginalisation more directly, including:

- social policies promoting an inclusive approach to diversity;
- social and economic policies directed to reducing inequalities in income and wealth; and
- taxation and welfare policies directed to ameliorating economic inequalities;

Intersectoral and community engagement

It is self-evident that there are other benefits to health associated with promoting physical activity including air pollution and climate change.

Action around the influences and policy principles outlined above belong in sectors of social practice beyond health. There are many reasons for physical activity as well as better health; there are many objectives at play in urban design beyond promoting physical activity. Hence the importance of respectful intersectoral and community engagement - a whole of society approach rather than 'health in all policies'.

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

In focus

Document [A71/19](#) provides a useful review of the current situation regarding epidemiology and policy/program implementation for women's, children's and adolescents' health including sexual and reproductive health, interpersonal violence and early childhood development. The document foreshadows a report on midwifery next year.

This report fulfills reporting requests included in [WHA57.12](#), [WHA69.2](#) and [WHA69.5](#). The Assembly is invited to note the report. There do not appear to be any resolutions on the horizon.

Background

The Global Strategy (2016-2030)

The [Global Strategy for Women's Children's and Adolescents' Health \(2016-2030\)](#) (launched by the UN SG in Sept 2015) identifies nine action areas (from [page 46](#)):

1. Country leadership
2. Financing for health
3. Health system resilience
4. Individual potential
5. Community engagement
6. Multisectoral action
7. Humanitarian and fragile settings
8. Research and innovation
9. Accountability for results, resources and rights

The logic of the Strategy links the action, in each of the nine *action areas*, to the implementation of a suite of *evidence based health interventions* set out in Annex 2 from [page 88](#) of the global strategy. Interventions are listed separately for women, children and adolescents.

The technical interventions are in turn linked to *health system policies and structures* needed to ensure their implementation. These are summarised in Annex 3 from [page 92](#). Annex 4 from [page 95](#) lists the *other sector policies and interventions* which would also be needed.

Chapter 6, which deals with implementation, speaks of three interconnected pillars which will underpin the delivery of the Global Strategy:

1. Country planning and implementation,
2. Financing for country plans and implementation, and
3. Engagement and alignment of global stakeholders.

The chapter highlights the concrete explicit commitments which are expected of different stakeholder groups. See 'Committing to Action' from [page 80](#) of the Global Strategy.

Operational plan

In May 2016 (in [A69/16](#)) WHO outlined an Operational Plan to take forward the Global Strategy (which was endorsed in [WHA69.2](#)). This plan emphasises country leadership and sets out five key activities for countries to follow. It notes the commitment of the 'H6 partnership' in the provision of technical support and

the Global Financing Facility (WB) in providing finance for L&MIC countries. Finally it emphasises 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 provided an overview of progress in women's, children's and adolescents' health and included a separate section focused on adolescents' health. [A71/19](#) is the second annual report.

Note that [WHA69.2](#) does not request reports on implementation of the Global Strategy itself including action areas and interventions. Rather it seeks reports on 'progress in women's, children's and adolescents' health'.

Independent Accountability Panel

The [2016 report](#) and the [2017 report](#) of the SG's Independent Accountability Panel are useful. The panel is required to provide an overview commentary on the implementation of the Global Strategy drawing on the various indicators adopted and reported through the SDGs and WHO's Global Health Observatory.

The development of the Global Strategy

In seeking to understand the processes and bureaucracies associated with the Global Strategy it is necessary to review some history. The infographic in Annex 1 of the Global Strategy (from [page 88](#)) traces out some of this history.

The first [Global Strategy \(for Women's and Children's Health\)](#) was launched by the UN Secretary-General in September 2010. This was in large part a response to the lack of progress in MDGs 4 & 5 on child and maternal health. The strategy was developed under the auspices of the United Nations Secretary-General with the support and facilitation of the Partnership for Maternal, Newborn & Child Health, based in WHO. An overview of the history and role of the PMNCH is [here](#).

As part of this first global strategy WHO was asked to coordinate a process to determine the most effective arrangements for global reporting, oversight and accountability on women's and children's health. In response, the Director-General established the Commission on Information and Accountability for Women's and Children's Health which reported in 2011 ([Keeping promises, measuring results](#)).

The ten recommendations from the UN Commission on Information and Accountability for Women's and Children's Health (as revised in 2016) are set out in Annex 5 of the Global Strategy from [page 97](#) and deal with:

- better information for better results,
- better tracking of resources for women's, children's and adolescents' health,
- better oversight of results and resources: nationally and globally.

One of the recommendations of the Commission was the establishment of an [independent Expert Review Group](#) to hold stakeholders accountable for their commitments to the Global Strategy. The iERG reported annually on implementation from 2012 to 2015 (and the conclusion of the MDGs process). The fourth and final report of the iERG is [here](#).

With the transition from MDGs to SDGs, in September 2015, a revised [Global Strategy](#) was developed (scheduled for 2016-2030 and this time including adolescents), and launched by the UN SG in Sept 2015, again under the auspices of the UN SG and the Every Woman Every Child 'movement', and with the support of the PMNCH. The UN SG also appointed a [High Level Advisory Group](#) to guide the strategic direction of Every Woman Every Child and the implementation of the new strategy.

The UN SG appointed the [Independent Accountability Panel \(IAP\)](#) at the same time as the launch of the revised Global Strategy. The IAP is hosted and supported by the PMNCH. The IAP was to produce an annual 'State of the World's Women's, Children's and Adolescents' Health' report and in so doing identify

areas to increase progress and accelerate action. See [Inaugural Report 2016](#) and [2017 Report](#) (focusing on adolescents).

As part of strengthening accountability relations WHO has developed the [indicator and monitoring framework](#) (described in [A70/37](#)) and WHO and partners have adopted the [Unified Accountability Framework](#).

As described in the UAF there are three pillars to the implementation plan for the Global Strategy: accountability (the Framework itself, the IAP, the indicators etc), technical support and financing.

Technical support is to be provided by the 'H6' (UNAIDS, UNFPA, UNICEF, UN Women, WHO, and the World Bank Group) and finance is centred on the Global Financing Facility (GFF) hosted by the World Bank.

Previous discussions

See [PHM Tracker links](#) to previous governing body discussions of the global strategy on women's children's and adolescents' health.

PHM Comment

The avoidable disease burden borne by women, children and adolescents is huge globally and very unevenly distributed. The Global Strategy and the Operational Plan foreshadow a range of sensible and highly strategic initiatives. PHM sees the implementation of the Global Strategy as aligned with the vision set out in the [People's Charter for Health](#).

However, the barriers to achieving the objectives of the strategy and effectively implementing the various initiatives and interventions are huge.

A detailed commentary on the Global Strategy was included in the PHM comment on this item at EB140 ([here](#)). That commentary (which remains relevant) touched upon:

- the bureaucratic complexity associated with the Global Strategy;
- worrying aspects of the Global Financing Facility arrangements (including the 'private sector' platform);
- the neglect of process indicators - as opposed to outcome indicators - in the Indicator and Monitoring Framework;
- the lack of any recognition of the macroeconomic and geopolitical determinants of poverty, inequality and undernutrition.

In addition to these issues, which remain critical to any assessment of the Global Strategy, our commentary here addresses:

- the mortality associated with unsafe abortion and the implications of the reinstatement of the 'global gag rule' by the current US administration;
- gender inequalities in power relations - domestic, marketplace, politics;
- the human rights dimension of women's, children's and adolescents' health; and
- the accountability discourse and advocacy drive.

Unsafe abortion

Unsafe abortion is a major contributor to [avoidable maternal mortality](#). [A71/19](#) (para 15) advises:

According to recent research on the safety of abortion, about 25 million of the estimated 55 million abortions performed between 2010 and 2014 were unsafe. Over 75% of abortions in Africa and Latin America were unsafe, and in Africa nearly half of all abortions were performed in the least safe circumstances, by untrained persons using traditional and invasive methods.

These figures may well deteriorate following the re-introduction by the Trump administration of the [Global Gag Rule](#). Member states should ensure that these figures appropriately updated are included in future reports regarding the Global Strategy.

[A71/19](#) (para 16) advises that:

In collaboration with the United Nations Department of Economic and Social Affairs, the Special Programme of Research, Development and Research Training in Human Reproduction has launched the open-access Global Abortion Policies Database ([WHO version](#), [UNDESA version](#)) containing abortion laws, policies, health standards and guidelines for all WHO and United Nations Member States. In addition to providing data on specific abortion policies, country profiles include sexual and reproductive health indicators, the list of human rights treaties ratified by the country in question, and links to the concluding observations of United Nations treaty bodies with selected extracts relating to abortion.

Women's health is determined by their timely access to a full range of reproductive health services. PHM supports freely and publicly available sexual and reproductive health services in all countries. This is a human right. PHM condemns the re-introduction of the Global Gag Rule; member states cannot assume that private donors will fill in the gaps left behind by the withdrawal of funding for reproductive health services by member states.

Gender inequalities in power: domestic, political and marketplace

[A71/19](#) mentions gendered power inequality in relation to violence (para 9) and in this context cites SDG5 (gender equality and empowerment).

However, the impact of patriarchy on the health of women, children and adolescents goes way beyond exposure to violence. Patriarchy impacts on access to food, education, health care (including reproductive health services), decent work and social security all of which contribute significantly to the health of women, children and adolescents.

Perhaps it is not surprising that WHO avoids the term 'patriarchy' since, as [Garrett highlights](#), the [leadership and membership of delegations to the World Health Assembly is decidedly tipped toward men](#). In 2005, only 16 percent of the national delegations were led by women, rising to 23 percent by 2015. Over that period, female leadership at the Assembly fell from 10 percent down to 5 percent for the nations in the Middle East.

Human rights

PHM appreciated the collaboration between WHO and the Office of the HCHR on a framework cooperation agreement to implement the [Working Group's recommendations](#), build institutional capacity and expertise, and ensure ongoing monitoring of progress in relation to women's and children's rights which was signed on 21 Nov ([here](#)). PHM strongly supports this initiative.

WHO has been far too timid in working with the HCHR in a wide range of issues affecting the right to health, in particular WHO's refusal to talk with the HCHR on their work on a treaty to regulate transnational corporations.

Accountability and advocacy

Attempts to strengthen the accountability of country governments, regional committees, philanthropies and various intergovernmental organisations have been a prominent part of the planning of the Global Strategy including in particular the Commission on Information and Accountability (2011), the Independent

Expert Review Group (2012), the Indicator and Monitoring Framework (2016), the Unified Accountability Framework (2015) and the Independent Accountability Panel (2016).

This struggle for accountability is admirable but in reality country accountability is weak to non-existent. Figure 2 of the Unified Accountability Framework imagines country accountability being mediated through 'regional peer review', health sector reviews, human rights reviews, gender assessments, parliamentary committees, citizen hearings, financial and performance audits and mortality and health audits. There is no evidence in the snow storm of official reports and celebrity committees that these mechanisms are providing significant drive for implementation.

It is a weakness of the WHO Constitution that member state sovereignty is a core value while member state accountability is discounted. These attitudes are reflected in [WHA69.2](#) in which the Assembly endorsed the Operational Plan for the Global Strategy. Member states are 'invited' to commit to the Global Strategy and the operational paragraphs are qualified by 'as relevant' and 'as appropriate'.

Despite the talk of accountability it is evident that implementation is conceived as being driven by high level advocacy and the top down creation of a social movement. This is well reflected in the [Every Woman Every Child 'Advocacy Roadmaps'](#).

12.4 mHealth

In focus

[A71/20](#) provides an overview of progress in the use of mobile wireless and other digital technologies for public health and health care. There are grounds for optimism and for scepticism. The penetration of mobile telephony globally has been extraordinary. There are thousands of apps promising extensive benefits in a wide range of fields. [A71/20](#) lists possible applications in areas of WHO priority where digital technologies and mHealth in particular are said to have great potential.

However, few of the apps and pilot projects have been evaluated in terms of effectiveness and there are significant challenges of scaling up from interesting pilots to wider application and integration within health systems.

[A71/20](#) outlines a set of priorities for the Secretariat in the near to medium term.

The debate on this item at EB139 ([PSR3](#)) was dominated by developing countries. Thailand offered caution in the midst of enthusiasm.

PHM has concerns that WHO's work in this space, in particular, its collaboration with - and receipt of funds from - the International Telecommunications Union (ITU) may breach the spirit if not the letter of the Framework for Engagement with Non-State Actors (FENSA).

Background

There is clearly a lot of enthusiasm for the potential applications of digital technologies in health care and public health.

Labrique et al (2013) summarise the possible applications of mHealth as follows:

1. Client education and behavior change communication (BCC)
 - Short Message Service (SMS)
 - Multimedia Messaging Service (MMS)
 - Interactive Voice Response (IVR)
 - Voice communication/Audio clips
 - Video clips
 - Images
2. Sensors and point-of-care diagnostics
 - Mobile phone camera
 - Tethered accessory sensors, devices
 - Built-in accelerometer
3. Registries and vital events tracking
 - Short Message Service (SMS)
 - Voice communication
 - Digital forms
4. Data collection and reporting
 - Short Message Service (SMS)
 - Digital forms

- Voice communication
5. Electronic health records
- Digital forms
 - Mobile web (WAP/GPRS)
6. Electronic decision support (information, protocols, algorithms, checklists)
- Mobile web (WAP/GPRS)
 - Stored information “apps”
 - Interactive Voice Response (IVR)
7. Provider-to-provider communication (user groups, consultation)
- Short Message Service (SMS)
 - Multimedia Messaging Service (MMS)
 - Mobile phone camera
8. Provider work planning and scheduling
- Interactive electronic client lists
 - Short Message Service (SMS) alerts
 - Mobile phone calendar
9. Provider training and education
- Short Message Service (SMS)
 - Multimedia Messaging Service (MMS)
 - Interactive Voice Response (IVR)
 - Voice communication
 - Audio or video clips, images
10. Human resource management
- Web-based performance dashboards
 - Global Positioning Service (GPS)
 - Voice communication
 - Short Message Service (SMS)
11. Supply chain management
- Web-based supply dashboards
 - Global Positioning Service (GPS)
 - Digital forms
 - Short Message Service (SMS)
12. Financial transactions and incentives
- Mobile money transfers and banking services
 - Transfer of airtime minutes

Roess (2017) provides a useful caution describing mHealth as a ‘data-free zone’. Roess comments that one of the factors limiting mHealth applications in LMICs is access to electricity to charge mobile phones.

Further references are listed [below](#) which generally bear out the observations that there have been many pilots but few robust evaluations and that issues of scaling up and integration within health systems remain significant challenges.

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

PHM Comment

Clearly mHealth has lots of current and future applications in well resourced and low resource settings. See table above.

However, the field is rich with one-off projects and blue sky promises and faces big challenges in scaling up and integrating good ideas into health care systems. It is a field in which enthusiasts and commercial interests play a significant role and caution is warranted.

The assumption that mHealth is a strategy to overcome the challenges of weak health systems is contradictory since the challenges of scaling up and integration are greatly magnified by weak health systems.

One of the challenges associated with the pilot-followed-by-scale-up model arises where the pilot is implemented by external agencies employing specially hired staff on short term report-dependent money. The alternative is to bed the pilot within the MOH from the beginning with the commitment of the MOH to scale up if successful. An example of this strategy is the [Liga Inan](#) project in Timor-Leste, a project connecting pregnant women with their midwives, which was embedded in the MOH from the beginning so the decision to scale up was seen as developmental rather than a complete shift in orientation.

PHM is concerned that the tone adopted in [A71/20](#) is unduly optimistic, at least as far as the short to medium term is concerned. Para 8, in particular, promises that digital technologies, and in particular mHealth, could play a major role in accelerating member states' progress "towards achieving universal health coverage including ensuring access to quality health services". The para lists the ways in which mHealth could help to realize this potential including:

- increasing access to health services;
- increasing access to sexual and reproductive health services; reducing maternal, child and neonatal mortality;
- reducing premature mortality from NCDs and NCD comorbidities;
- increasing global health security;
- increasing the safety and quality of care; and
- increasing patient, family and community engagement.

PHM is concerned that WHO's relationship with the International Telecommunications Union (ITU), which appears to be funding most of its work on mHealth, may breach the spirit and perhaps the letter of WHO's Framework for Engagement with non-State Actors (FENSA).

[A71/20](#) notes that the Secretariat is collaborating with the International Telecommunications Union (ITU) to raise awareness, record trends, build capacity, establish guidance, and generate and document evidence on digital health, including mHealth, as a tool to promote person-centred, integrated service delivery.

The ITU is a regular donor to WHO giving \$464,000 in 2014-15 ([Budget Portal](#)) and \$200,000 in 2016 ([A70/INF.4](#)). It appears that ITU support has contributed to [The MAPS Toolkit](#): (mHealth Assessment and Planning for Scale in RMNCH) and [Scaling up digital health](#) (in relation to NCDs: *Be He @lthy, Be Mobile*). The bulk of ITU funding in 2014-15 appears to have been directed to NCDs work (Budget Portal).

The ITU is a multilateral public private partnership. It has a membership of 193 countries and almost 800 private-sector entities and academic institutions ([about](#)).

In July 2014 the ITU through the Telecom Standards Newsletter announced that GSK and Public Health England were joining *Be He @lthy, Be Mobile*, joining BUPA, Verizon, the IFPMA, the African Development Bank and the NCD Alliance as existing partners. In February 2015 the ITU announced that Sanofi was joining *Be He @lthy, Be Mobile* "harnessing power of ICTs to deliver health-care solutions" (Mena Report. Feb. 28, 2015).

It appears that the ITU may be mediating contributions to WHO from a wider range of *Be He @lthy, Be Mobile* partners.

WHO's Scaling up digital health [webpage](#) advises that:

"In 2012, WHO and the International Telecommunications Union (ITU) founded a joint program to provide guidance. The initiative, *Be He @lthy, Be Mobile*, helps governments create safe, sustainable programs which deliver the benefits of mHealth at scale."

"The initiative aims to standardize the design and deployment of mHealth programs based on best practices. It does this by developing global handbooks containing technical and operational guidance on how to create mHealth services for a specific diseases or behaviours. It then helps countries tailor the content for use in a local setting, launch the service, and evaluate the results."

"To ensure that programs are sustainable and that they support existing health services, all programs are owned by the government. This also builds national capacity to develop additional mHealth services for other diseases, strengthening the health system more broadly."

If robust independent evaluations have been carried out in relation to *Be He @lthy, Be Mobile* they are not cited on the *Be He @lthy, Be Mobile* webpage.

WHO's framework for engagement with non-state actors (FENSA, [WHA69.10](#)) articulates a number of principles governing WHO's engagement with non-State actors including [any engagement must]:

- (a) demonstrate a clear benefit to public health;
- (d) support and enhance, without compromising, the scientific and evidence-based approach that underpins WHO's work;
- (e) protect WHO from any undue influence, in particular on the processes in setting and applying policies, norms and standards;
- (f) not compromise WHO's integrity, independence, credibility and reputation;
- (g) be effectively managed, including by, where possible avoiding conflict of interest and other forms of risks to WHO.

Para 71 of the Framework provides that: "Any financial contribution received by WHO that is subsequently discovered to be noncompliant with the terms of this framework shall be returned to the contributor."

Clause 13(b) of the policy on engagements with private sector entities provides that "Financial contributions may not be sought or accepted from private sector entities that have, themselves or through their affiliated companies, a direct commercial interest in the outcome of the project toward which they would be contributing, unless approved in conformity with the provisions for clinical trials or product development (see paragraph 36 below)."

Clause 14(c) provides that "the proportion of funding of any activity coming from the private sector cannot be such that the programme's continuation would become dependent on this support"

The PBAC has the responsibility for overseeing the implementation of FENSA. PHM urges member states to enquire as to whether the PBAC has satisfied itself that the relationship with the ITU does not breach the FENSA provisions and if not to request that it to undertake such an enquiry.

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12.5 Improving access to assistive technology

In focus

[A71/21](#) defines assistive technology, reviews the need, outlines some of the barriers to ensuring universal access to appropriate assistive products and summarises WHO's approach to supporting member states in this field.

The draft resolution contained in [EB142.R6](#) urges member states to adopt policies, ensure training, promote access, invest in research and development, collaborate, collect data, reduce barriers and encompass emergency preparedness with a view to improving access to assistive technologies. The draft resolution would request the DG to prepare a report, provide technical and capacity building support and develop standards.

Background

[A71/21](#) outlines the background to this initiative.

The Global Cooperation on Assistive Technologies, established in 2014 is working to implement four strategies to improve access to appropriate assistive technologies:

1. Putting in place a coherent policy framework
2. [Priority assistive products list](#)
3. Personnel: technology training package
4. Promoting best practice in models of assistive products service provision

WHO organised a conference in Geneva in August 2017 (the [GREAT Summit](#)) to discuss service delivery, research education and training related to assistive technology policy, products, personnel, provision and use. The GREAT Summit has contributed to:

- advancing the global priority research agenda;
- establishing thematic research collaborations in:
 - effects, costs and economic impact of assistive technology;
 - assistive technology policies, systems, service delivery models and best practices;
 - high-quality and affordable assistive technology;
 - human resources for the assistive technology sector;
 - standards and methodologies for the assessment of assistive technology needs and unmet needs;
- identifying new research funding opportunities;
- accelerating innovative education and certification;
- working towards a common impact assessment tool; and
- showcasing ground-breaking research and education.

See [Tracker for links](#) to previous governing body discussions of disability and assistive technologies.

PHM Comment

This is a very constructive initiative.

However PHM believes that both [A71/21](#) and [EB142.R6](#) would have been improved with greater attention to the role of disabled people as experts in their own needs, both as individuals and through self-help organisations.

Both [A71/21](#) and [EB142.R6](#) refer to the [Convention on the Rights of Persons with Disabilities](#). The guiding principles of the Convention (which are cited in WHO's [Global Disability Action Plan 2014-2021](#), adopted in [WHA67.7](#)) are:

1. Respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons
2. Non-discrimination
3. Full and effective participation and inclusion in society
4. Respect for difference and acceptance of persons with disabilities as part of human diversity and humanity
5. Equality of opportunity
6. Accessibility
7. Equality between men and women
8. Respect for the evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identities

While WHO has endorsed these principles in [WHA67.7](#), they are not reflected very strongly in the text of [A71/21](#) nor the commitments proposed in [EB142.R6](#).

PHM urges member states to consider the following additions to the draft resolution.

New subclause in operative paragraph 1 (The Assembly urges member states ...)

- to ensure that the development and provision of assistive technologies is done in a manner which respects the inherent dignity and individual autonomy, including the freedom to make one's own choices of persons;
- to ensure that the experience and judgement of people living with disabilities is respected and harnessed in policy making, design, access to and use of assistive technologies;

New subclause in operative paragraph 2 (The Assembly requests the DG ...)

- to continue to engage with users of assistive technologies to ensure that the principles articulated in the Convention on the Rights of Persons with Disabilities are fully realised in WHO's normative work and technical support in this field;

12.6 Maternal, infant and young child nutrition

In focus

[A71/22](#) provides:

- a progress report on the comprehensive implementation plan (CIP) on maternal, infant and young child nutrition, including
 - a report on progress towards the six global targets and the five actions including an update on the final four core indicators (paras 20-21);
 - an analysis of the proposal to extend to 2030 the 2025 targets on maternal, infant and young child nutrition (see para 8) so as to align the CIP with the SDG agenda to 2030 (noted by EB142 in [EB142\(6\)](#));
- a progress report on the implementation of the Code of Marketing of Breast-milk Substitutes.

[A71/23](#) conveys a proposed approach for preventing and managing conflicts of interest in the policy development and implementation of nutrition programmes at the country level. The report includes: a summary of the typologies and general principles that have been considered in the development of the tool and a summary of the main steps covered by the tool.

Background

Comprehensive Implementation Plan

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

The Plan was conceived as covering a 13 year time frame, from 2012-2025, with biennial reporting (para 21). The report to be prepared for WHA71 through EB142 will report on progress with respect to implementation and propose an extension to 2030.

The comprehensive implementation plan ([CIP](#)) was endorsed by the Health Assembly in resolution [WHA65.6 \(2012\)](#). This resolution also:

- urged member states to implement the CIP including:
 - strengthening measures to control the marketing of breastmilk substitutes; and
 - safeguarding against potential conflicts of interest in nutrition programs;
- requested the DG to:
 - provide further guidance on the promotion of foods for young children;
 - progress the monitoring and evaluation of nutrition policies;
 - develop appropriate tools to safeguard against possible conflicts of interest in nutrition programmes.

These issues were further progressed at WHA67 (2014) with decision [WHA67\(9\)](#) which:

- endorsed the idea of a core set of outcome and process indicators and extended set of indicators which countries may choose to report on (see [Annex 1 to EB134/15](#));
- endorsed 7 core indicators for monitoring the CIP and asked for further work on indicators;
- asked the Secretariat to proceed with the work on COI and risk assessment;
- noted the work done on inappropriate promotion and asked that it be completed for WHA69.

At WHA68 in May 2015 the Assembly decided (see [WHA68\(14\)](#)) to approve the additional core indicators ([A68/9](#)) to be reported from 2016; and approved in principle the remaining indicators and requested further work on the operationalisation of these remaining indicators; see paras 20 and 29 of [A71/22](#) regarding these additional indicators. See [PHM comment](#) at WHA68 on the politics of this debate over indicators.

The CIP returned to WHA69 with [A69/7](#) which reported on:

- progress made in carrying out the CIP;
- progress in implementing the Code on the Marketing of Breast-milk Substitutes;
- progress with respect to risk assessment and risk management regarding conflict of interest in nutrition programmes - see [A71/23](#) for the latest phase of this work;
- development of draft guidance regarding the inappropriate promotion of foods for infants and young children (articulated fully in [A69/7 Add.1](#) and adopted in [WHA69.9](#)).

The [WHO/UNICEF Global targets tracking tool](#) provides access to basic outcome indicators (stunting, anaemia, low birthweight, overweight, exclusive breastfeeding and wasting) but doesn't include the various process and program environment indicators.

The [Nutrition Landscape Information System \(NLIS\)](#) includes a wide array of indicators including some which are close to the core set adopted for the CIP.

In [A69/7 Add.2](#) the Assembly was advised of the UN Decade of Action on Nutrition and in Resolution [WHA69.8](#) the Assembly reinforced much of what was already happening but in a new move invited member states to make 'SMART' commitments in accordance with the Rome Declaration emerging from the ICN2. See [A70/30](#) for an update on the Decade of Action.

[GINA](#) (the global database on the implementation of nutrition action) has a tab for 'commitments' and as of early Jan 2018 there were only two countries with commitments registered.

See also [WHO-UNICEF Technical Expert Advisory Nov 2017](#) guidance on the Global Monitoring Framework for more detail on indicators.

Earlier versions of both [A71/22](#) and [A71/23](#) were considered and noted at EB142. In [EB142\(6\)](#) the Board noted the analysis of the extension to 2030 of the 2025 targets on maternal, infant and young child nutrition; approved the four remaining indicators of the Global Monitoring Framework, as set out in document [A71/22](#); and invited Member States to consider the full list of indicators in their national nutrition monitoring frameworks and report in accordance with decision [WHA68\(14\)](#).

See [Tracker links](#) to previous discussions of the Comprehensive Implementation Plan, the ICN2 and the Decade of Action.

Conflict of Interest in Nutrition Programmes

In [WHA65.5](#) the Assembly endorsed the CIP. The resolution had two paragraphs referring to conflict of interest (COI):

- In Operative Para 2 member states were urged to establish a dialogue with 'relevant national and international parties' and to form alliances and partnerships to expand nutrition actions with the establishment of adequate mechanisms to safeguard against potential conflicts of interest;
- In OP 3 the Director-General was requested ... "(3) to develop risk assessment, disclosure and management tools to safeguard against possible conflicts of interest in policy development and implementation of nutrition programmes consistent with WHO's overall policy and practice.

As described in [A71/23](#) (paras 4-6) the Secretariat convened a technical consultation, held in Geneva on 8 and 9 October 2015, "on addressing and managing conflicts of interest in the planning and delivery of nutrition programmes at country level" following which the Secretariat devised a "draft approach on preventing and managing conflicts of interest in policy development and implementation of nutrition programmes at country level". This draft approach was subject to public consultation in September 2017 and the approach described in [A71/23](#) has been produced taking into consideration the views expressed in that consultation.

Not only is the proposed tool restricted to country level application but it is also restricted to consideration of formalised 'engagements'.

It is interesting to return to 2012 and the debate out of which WHA65.6 emerged.

The draft resolution, sponsored by Swaziland and Uganda, which ultimately became WHA65.6 (see [A4 at WHA65](#)) initially urged member states to establish a national mechanism to deal with conflicts of interest and would request the DG “to establish a guideline and mechanism to deal with conflicts of interest for the Secretariat and partnerships that emerge”.

An alternative, draft decision was also tabled (by Canada supported by Mexico, Mozambique, Peru, UK, Tanzania, the USA and Zimbabwe) which would simply endorse the CIP as circulated.

Across four meetings of Committee A ([A4](#), [A7](#), [A8](#), [A9](#)) and several informal drafting groups the idea of asking the DG to address conflicts of interest arising in ‘partnerships’ was completely removed and the only reference to partnerships was transferred to OP2(3) in which member states are urged to take action.

Two years later (May 2014), in [WHA67\(9\)](#), the Assembly asked the DG “to convene informal consultations with Member States on risk assessment and management tools for conflicts of interest in nutrition, for consideration at WHA69 (2016)”. However, [A71/23](#) advises (para 4) that when the consultation was organised it was restricted to conflicts of interest at the country level, which is consistent with the restriction of the tool announced in A71/23 to the country level. Presumably the reach of WHA67(9) was regarded as being somehow limited by the restrictions imposed by WHA65.6.

See the [IBFAN](#) and the [WFPHN](#) contributions to the Consultation for robust criticisms of the conceptualisation of conflict of interest and the failure to address COI risks associated with international public private partnerships.

PHM Comment

Comprehensive implementation plan: need to address global food systems

The global nutrition situation is poor, particularly in South Asia and Africa, and progress is slow (in some cases non-existent). See biennial reports on the CIP in 2018 ([A71/22](#)), 2016 ([A69/7](#)) and 2014 ([B134/15](#)). The implementation of the ‘commitments’ of the Decade of Action has been too slow.

The field is populated by a myriad of UN agencies, global public private partnerships, global philanthropies all with different mandates, accountabilities and strategic frameworks. In this system, there is a huge emphasis at the global level on (voluntary) ‘commitments’ (the latest, under the decade of action) and token institutional reforms (under the CIP).

In the context of strategies designed to avoid the key issues, the investment in independent monitoring and effective regulation is also quite inadequate. The fundamentals are being obscured by the dance of bureaucracy. In this context it is useful to return to the [PICSO&SM Statement on Nutrition](#) at ICN2 in 2014.

Access to food and adequate nutrition is intrinsically linked to poverty; poverty is largely a distributional issue; a strategy that does not tackle widening inequality will not resolve the nutrition challenge; tackling global poverty and inequality while returning to ecological sustainability requires a radical rejection of economic globalisation and neoliberal hegemony.

Access to food and the quality of affordable foods is a *food systems* function; contemporary food systems globally are increasingly dominated by transnational food corporations and their preferred model of input-intensive food production and globalised supply chains. In the take-over of food systems by big food, the use of loan conditionalities and trade agreements to destroy publicly owned food reserves and price supports have been prominent strategies of the bilateral donors. The attacks on the Public Distribution System in India as ‘trade distorting’ exemplifies.

Meanwhile small farmers coping with the costs of seeds, herbicides, pesticides and water and carrying usurious debt burdens are struggling to cope with climate change as well as low and volatile prices.

Climate change, soil degradation and water shortages/waste present new challenges for farmers and for food production. The threat of climate change demands fundamental reforms to energy systems. Soil degradation and water issues are inherently part of the food systems of neoliberal industrial agriculture.

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. We are convinced that food sovereignty is a fundamental precondition to ensure food security and guarantee the human right to adequate food and nutrition. In this context, it is necessary to reaffirm the centrality of small-scale and family food producers as the key actors and drivers of local food systems and the main investors in agriculture. Their secure access to, and control over, resources such as land, water and aquatic resources, adequate mobility routes, local seeds, breeds and all other genetic resources, technical and financial resources, as well as social protection, particularly for women, are all essential factors to ensure diversified diets and adequate nutrition.

Patriarchy is a critical part of this picture from the unequal distribution of household food, to the differential impact of industrial agriculture on household finances, to the displacement of the anger which is properly owed to exploitative agriculture.

The convolutions of strategies, indicators and forums take place in an alternative universe. They create a shadow play while the politicians and executives of the transnational capitalist class continue to drive inequality, the globalisation of food systems and the degradation of the human environment; and deploy the divisions of gender, religion and ethnicity to displace and weaken any opposition.

It is imperative to tackle the political, social, cultural and economic determinants of malnutrition in all its forms, including stunting, wasting, micronutrient deficiencies, overweight and obesity, and diet-related non-communicable diseases. Policies, programmes and action plans on food and nutrition should be framed by an unambiguous understanding of the rights to adequate food and nutrition, health and safe water, as fundamental human rights, which identify people as rights-holders and states as duty-bearers with an obligation to respect, protect and fulfil these and other related rights.

Maternal, infant and young child nutrition needs to be taken to the streets and villages. A global convergence of social movements around solidarity, human rights and ecological sustainability, including food sovereignty, will be needed to counter the greed, power and irresponsibility of the 1%.

Conflict of interest in global public private partnerships (GPPPs)

Global public private partnerships, in particular SUN (Scaling up Nutrition), GAIN (Global Alliance for Improved Nutrition) 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 globalising trade in agriculture and processed foods and in local production and retail (Moodie et al 2013, Hawkes 2011, Kraak et al 2011, Swinburn et al 2015).

The [Social Movements Statement on Nutrition](#), released at ICN2 in November 2014, comments that:

Weakened governance and corporate capture of policy space is in direct contradiction to the rights-based advocacy of social movements. We note with alarm the ongoing diminishment of governance and governments, and correlated corporate capture of policy space at all levels, particularly evident at ICN2. This includes significant increases in public-private partnerships that frequently result in strengthened corporate lobbies and influence. Furthermore, shrinking space for governments is resulting in a loss of accountability of governments in relation to food, nutrition and

other human rights obligations. Corporate capture of policy space respecting nutrition and food poses substantial risks to human and environmental health, social welfare, and the future of agriculture, fisheries and livestock keeping. Public policy must be in the public interest and it's critical to fully address conflict of interests.

The [Vision Statement](#) adopted by public interest civil society organisations participating at ICN2 called for: “democratic governance of food and nutrition and for government-led normative and regulatory frameworks ... ensure proper accountability of all actors involved”:

Governments' policy space must be protected, in all phases and at all levels, against conflicts of interest introduced by inappropriate relationships with powerful economic actors, including transnational corporations. In this respect, Member States and UN agencies are urged to design and implement effective rules and regulations on conflict of interest, and review and potentially terminate or re-design in conformity to these rules and regulations all Public-Private Partnerships (PPP) and multi-stakeholder arrangements.

The 2012 maneuvers which removed the proposed request to the DG (in what became WHA65.6) to consider COIs affecting partnerships suggest a concern among the rich countries to avoid any focus on COI in GPPPs (and a certain lack of awareness among many L&MIC delegates of the COI risks associated with such partnerships).

The interpretation by the Secretariat of [WHA67\(9\)](#) as applying only ‘at the country level’ suggests that the Secretariat is unwilling or unable (perhaps because of the wording of WHA65.6) to address COIs in GPPPs.

WHO does in fact have a Partnerships policy ([here](#)) which was adopted in 2010 in [WHA63.10](#). This policy 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](#).

References

Moodie, R., et al. (2013). "Profits and pandemics: prevention of harmful effects of tobacco, alcohol, and ultra-processed food and drink industries." *The Lancet* 381(9867): 670-679.

Hawkes, C. (2011). "Public health sector and food industry interaction: it's time to clarify the term 'partnership' and be honest about underlying interests." *European Journal of Public Health* 21(4): 400-403.

Kraak, V. I., et al. (2011). "The accountability of public-private partnerships with food, beverage and quick-serve restaurant companies to address global hunger and the double burden of malnutrition." *United Nations System Standing Committee on Nutrition : News* 39(11-24).

Swinburn, B., et al. (2015). "Strengthening of accountability systems to create healthy food environments and reduce global obesity." *The Lancet* 385(9986): 2534-2545.

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

In focus

[A71/24](#), [A71/24 Add.1](#) and [A71/42](#)

[A71/24](#) reports on progress made in implementing decision [WHA70\(10\)](#) adopted in May 2017 after consideration of the report of the 2016 PIP Framework Review Group ([A70/17](#)) and the report of the Secretariat on collaboration with the Secretariat of the Convention on Biological Diversity ([A70/57](#)).

[WHA70\(10\)](#) requested the DG to:

- 8(a) take forward the recommendations of the PIP Framework Review Group ([A70/17](#));
 - [A71/24](#) reports that this is underway;
 - **Secretariat plans** to have completed required actions by WHA72;
- 8(b) conduct a thorough and deliberative analysis of the issues raised by the Review Group's recommendations concerning seasonal influenza and genetic sequence data;
 - [A71/24](#) reports on:
 - the development of [Scoping Paper](#);
 - consultations undertaken in Nov 6-7, 2017 on the inclusion of seasonal influenza and genetic sequencing data;
 - the information session scheduled for April 2018;
 - **Secretariat plans** finalise this analysis in time for EB146 and then WHA72;
- 8(c) to continue supporting the strengthening of regulatory capacities and carrying out burden-of-disease studies;
 - [A71/24](#) reports that:
 - regulatory strengthening and burden of disease studies included in [Partnership Contribution Implementation Plan \(2018-2023\)](#);
 - publication of [regulatory preparedness guidelines](#) will facilitate timely marketing authorisation;
 - **Secretariat plans** to:
 - continue implementing the PC Implementation Plan (2018-2023);
 - conclude more SMTA2s;
 - continue engagement with secretariat of CBD and other secretariats on access and benefit sharing;
 - reporting to WHA72 through EB144;
- 8(d) to continue encouraging manufacturers and other relevant stakeholders to engage in PIP Framework efforts, including, where applicable, by entering into Standard Material Transfer Agreements 2 and making timely annual PIP Partnership Contributions;
 - [A71/24](#) reports that progress is being made;
 - see **Secretariat plans** above;
- 8(e) to request the External Auditor to perform an audit of PIP Partnership Contribution funds;
 - [A71/24](#) reports approval in general by the External Auditor with some recommendations which have been accepted and are being implemented;
 - see **Secretariat plans** above;
- 8(f) to continue consultations with the Secretariat of the Convention on Biological Diversity regarding, in particular, the relationship between the PIP Framework and the Nagoya Protocol, (see [EB140/15](#) and WHO webpage on [WHO negotiations with the Secretariat of the CBD](#));
 - [A71/24](#) reports on:
 - on-going discussions involving secretariats of WHO, CBD, FAO and OIE;
 - [Qs and As document](#) prepared by the four secretariats on the application of Nagoya;
 - workshop planned for June 2018;

- see **Secretariat plans** above.

The Secretariat proposes a Decision approving the Secretariat plans as noted above.

[A71/42](#) provides the Executive Summary of the biennial implementation report for 2018 (in full [here](#)).

The report covers:

- laboratory and surveillance capacity;
- global pandemic influenza vaccine production capacity;
- agreements with industry;
- use of partnership contribution revenues;
- review of experience in using the definition of PIP biological materials (handling of genetic sequence data).

The Assembly is invited to note the report.

Background

About the Pandemic Influenza Preparedness Framework (PIPF)

The pandemic influenza preparedness framework ([here](#)) was developed because of concern regarding inequities that had emerged in the context of WHO influenza sharing through what was then known as the Global Influenza Surveillance Network (GISN). Countries shared influenza viruses with WHO linked laboratories, which in turn shared candidate vaccine viruses with vaccine manufacturers, but no benefits were returned to WHO or the countries that shared the influenza viruses. In fact countries that shared the influenza viruses often were not able to gain access to the vaccines, either because there were unavailable or because they were unaffordable. Discussions over the inequities peaked in 2007, leading to intensive negotiations and finally a [Framework](#) for virus and benefit sharing in 2011.

Under this Framework recipients of viruses have to share benefits. Benefits are shared through two channels: SMTA agreements and partnership contributions.

Recipients of biological materials are required to enter into an agreement with the WHO known as the Standard Material Transfer Agreements (SMTA) to indicate how the benefits of accessing these materials are to be shared with the WHO. Two different SMTAs are provided for. SMTA1 is for entities within the GISRS receiving materials. SMTA2 is for entities outside the GISRS receiving materials. The benefits shared under SMTAs are largely in kind benefits. (See details of SMTAs in Annex 1 & 2 of the [PIP Framework](#).)

Entities outside the GISRS are also expected to make 'partnership contributions' to WHO to help support the Global Influenza Surveillance and Response System (GISRS). See [Financial Report at Annex 1](#) of 2016 PIP Framework Partnership Contribution 2013-16 Annual Report. The distribution of the partnership contribution obligation is determined in accordance with rules (8 May, 2013) [here](#). The use of the partnership contribution is governed by Decision [EB131\(2\)](#) from May 2012: broadly 70% is to be used for preparedness (laboratory and surveillance) and 30% reserved for to support response capability. See [PC webpage](#) for more.

An Advisory Group was set up to monitor implementation of the PIP framework. This Group meets twice a year.

More about PIP on WHO website [here](#). See in particular the detailed discussion of genetic sequencing data ([GSD](#)).

See [Tracker links](#) for previous discussions of the PIP Framework.

PHM Comment

PHM urges member states to adopt the decision proposed in [A71/24](#) and to note [A71/42](#).

Genetic sequence data should be treated in the same way as the viral isolate under the PIP Framework. Access to and use of genetic sequence data should trigger benefit sharing.

Databases that wished to host sequence data should implement a standard user agreement that applies the Framework's benefit-sharing obligations to users accessing sequence data and allows such users to be tracked.

The partnership contribution paid by manufacturers should be updated, given that the current running costs of the Global Influenza Surveillance and Response System is estimated to be US\$122 million.

Member States should ensure that access to seasonal influenza viruses is balanced by fair and equitable benefit sharing. Preferably this is achieved by creating a new instrument to govern the sharing of seasonal influenza virus, rather than taking action that might undermine the PIP Framework.

The PIP principles of virus sharing and benefit sharing should be applied to other pathogens accessed by WHO during times of emergencies but how this might be operationalised requires further study and discussion.

12.8 Rheumatic fever and rheumatic heart disease

In focus

[A71/25](#) is a short overview of the epidemiology and public health principles for the prevention, control and elimination of rheumatic fever. It summarises barriers to progress and recommends actions for member states and outlines actions for the Secretariat.

[EB141.R1](#) proposes a resolution which suggests action for member states, international partners, and for the WHO Secretariat.

Background

The overview provided in [A71/25](#) is comprehensive and useful. The omission of reference to skin disease as a possible precursor to rheumatic fever (see Carapetis et al (2011) below) should be corrected in future iterations.

Reference

Carapetis, J. R. and L. J. Zühlke (2011). "Global research priorities in rheumatic fever and rheumatic heart disease." *Annals of Pediatric Cardiology* 4(1): 4-12.

There is circumstantial evidence from the Aboriginal population in Australia that skin infection may play a role in RF pathogenesis[47] which, in turn, raises the possibility that community-based programmes to reduce rates of impetigo and underlying scabies--increasingly being studied and demonstrated to be effective[48]--may provide an avenue to large-scale primary prevention of RF/RHD. However, for now, this remains only hypothetical. But this deserves further research, potentially by testing more intensively the hypothesis that streptococcal skin infection might, directly or indirectly, have a causative link with RF, or through intervention studies using either controlled trials or observational studies to map the rates of skin infections against rates of RF/RHD and monitoring changes over time.

PHM Comment

PHM commends the Secretariat paper and urges the Assembly to adopt the proposed resolution.

It is useful to underline the role of poor housing, overcrowding and delayed access to primary health care.

It is useful also to underline the emphasis in the report on integrating the prevention and management of rheumatic fever in existing strategies and community programmes; and hence the importance of health systems strengthening oriented around primary health care.

12.9 Eradication of poliomyelitis

In focus

This item (informed by [A71/26](#)) is the second of two items on polio (Item 11.3 deals with transition planning).

[A71/26](#) provides an update on progress made against the objectives of the Polio Eradication and Endgame Strategic Plan. It summarizes the current situation, including details of:

- continuing work to achieve the global interruption of poliovirus transmission;
 - wild type 1 in Nigeria, Afghanistan and Pakistan;
 - circulating vaccine derived type 2 in Syria and DRC;
- the phased removal of oral polio vaccine (and associated shortages of inactivated vaccine);
- intensified efforts to accelerate laboratory containment; and
- a financial update of the programme to rapidly achieve global certification of eradication of all wild poliovirus types.

[A71/26 Add.1](#) presents a draft resolution focusing on containment. It appears that this draft resolution has been prepared on the recommendation of the Polio Global Certification Commission which held a special meeting 23-25 October 2017.

The background to this focus on containment is evident in the briefings provided to the Global Certification Commission at this meeting ([here](#), pp6-9) which included reference to:

- two recently reported breaches of poliovirus containment (Belgium in 2014 and Netherlands in 2017);
- slow implementation of the [Containment Certification Scheme](#) (delays in establishment of National Containment Authorities by countries); delays in countries submitting requests for Certification of Participation [in the Global Containment Certification Scheme];
- complacency arising from the lack of deadlines for participation;
- resistance to reducing the number of Polio Essential Facilities [ongoing containment] ;
- resistance to implementing controls required for the [Global Action Plan](#) for Containment (as recommended by the [Containment Advisory Group](#)).

The bottom line was “an urgent need to accelerate the containment certification process”.

The draft resolution addresses this need with specific provisions addressing the perceived barriers.

[A71/26 Add.2](#) reports on financial and administrative implications.

Background

The starting point for both polio items is decision [WHA70\(9\)](#). This decision sets out the key priorities at this stage of the Global Polio Eradication Initiative (GPEI) including:

- pursue eradication in endemic countries;
- manage continuing surveillance and certification of eradication; and
- develop post-certification polio strategy.

See the [Tracker](#) for links to earlier governing body discussions of polio.

See also Global Polio Eradication Initiative [website](#).

PHM Comment

Too much has been invested in the GPEI to allow it to fail now. PHM appreciates the strategic and operational challenges facing the GPEI; commends the technical experts, the managers, the practitioners

and the volunteers for their dedication; encourages the governments of the 26 at risk countries; and urges the donors to continue to fund the Initiative up to eradication and beyond.

PHM appreciates the concerns expressed by the Global Containment Commission and urges delegates to adopt the draft resolution.

There are a number of longer range issues to be noted as insights into global health governance and lessons for global health policy making.

In some degree these issues are tied up with the role of the Bill and Melinda Gates Foundation (B&MGF) in funding the GPEI and their relationship with WHO. (See recent commentary on Bill Gates's relationship with WHO in [The world's most powerful doctor: Bill Gates](#)). Total funding for the GPEI since 1985 has been \$US14 billion, including \$US2.9 billion from the B&MGF and \$US1.5 billion from Rotary International ([GPEI](#)). In 2016 the BMGF contributed 29% of the funding for WHO expenditure on the GPEI. 62% of BMGF contribution to WHO went to polio in that year. (Data from [A70/40](#) and [A70/INF./4.](#))

The vaccine is a magic bullet. Polio is spread through faecal contamination of food and drink. Some of that \$US14 billion could have contributed to more effective sanitation, sewerage and clean water. However, investing in rural and urban infrastructure is a function of more broadly based social and economic development and this depends on how different countries fit into the global economy, on depth and norms of public financing, and on a commitment to equity as well as health. These in turn are determined by neoliberal globalisation; by tax competition and tax avoidance; and by the neoliberal ideology of small government and privatisation.

The opportunity costs of *eradication*, particularly in the final stages, are much higher than *control*. The last mile is the most expensive. A less ambitious polio control program could, in theory, have released funds for more efficient applications (measured, for illustration's sake, in terms of DALYs averted per \$ spent). Historians of public health will compare the policy drivers and technical strategies of polio eradication with those of malaria (failure) and smallpox (success) and measles (partially achieved).

15.1 WHO programmatic and financial reports for 2016–2017, including audited financial statements for 2017

Contents

- [In focus](#)
- [Background](#)
- [PHM Comment](#)
- [Notes of discussion](#)

In focus

[A71/28](#) reports on expenditures and achievements through WHO's Programme Budget 2016-17. It is styled as a 'WHO Results Report' and is well illustrated with photographs. The narrative has been clearly shaped by a marketing objective the infographics on financing are useful. However it is very much a 'glass half full' report.

[A71/29](#) presents the audited financial statements for the year ending 31 Dec 2017, the second half of the 16-17 biennium.

[A71/INF./2](#) reports on voluntary contributions by fund and by contributor, for 2017. Much of the data reported on here is also included in A71/28 in various infographics.

The Assembly will take the advice of the PBAC28 in considering these reports and the Assembly will be invited to adopt a resolution 'Accepting' A71/28 and A71/29.

Background

See also the [WHO Budget Page](#) and [WHO PB Portal](#).

See [Tracker links](#) to previous PB biennial report discussions, including

- Item 12.2 at WHA68 which adopted PB16-17;
- Item 20.2 at WHA69 which considered the financing of PB16-17; and
- Item 20.1 at WHA69 which reviewed programmatic and audited financial reports for PB14-15.

PHM Comment

It is intriguing that the report on PB16-17 before the Assembly ([A71/28](#)), while it is styled a Results Report, makes no reference to the complicated results chain spelt out in PB16-17 ([A68/7](#)). PHM has previously criticised aspects of this results chain, in particular, the often meaningless 'output indicators'. However, the 'deliverables' are more meaningful because they spell out in detail exactly what the Secretariat expects to be doing over the biennium.

Significant issues arising from PHM perspective:

- continuing dominance of VCs of ACs in the funding of the WHO Secretariat;
- continued refusal of most donors to contribute to the Core Voluntary Contributions Account (CVCA), essentially untied donations; (see p6 of A71/INF./2);
- continuing under-funding of the WHO Emergencies Contingency Fund; currently standing at \$18.3m instead of the target of \$100m;
- the continued under-funding (less than half) of the very low budget for SDH (\$36m);
- the continuing under-funding of the very modest NCDs budget;

- the huge cost of polio eradication particularly in Africa and Middle East (see DG comment about the 'last mile' on page 2 of A71/28) and the vulnerability of the African region in the face of the loss of some or all of that funding which is providing important support to a range of WHO programmes beyond polio; note the huge investment of Gates in polio.

The donor chokehold over WHO's real work program remains in place, expressed in the freeze on ACs and the refusal to untie VCs.

15.2 Financing of the Programme budget 2018–2019

Contents

- [In focus](#)
- [Background](#)
- [PHM Comment](#)
- [Notes of discussion](#)

In focus

[A71/30](#) reports on the state of financing of PB18-19 ([A68/7](#)) as at 31 March 2018. It makes grim reading. As of 31 March, 3 months into the biennium, only 73% of the budgeted expenditure is secure.

Figure 1 depicts significant funding shortfalls for a range of important programmes. Fig 2 highlights the 10 programme areas which receive 80% of specified voluntary contributions.

Background

See also:

- [A71/29](#) which presents the audited financial statements for the year ending 31 Dec 2017, the second half of the 16-17 biennium; see in particular the undersubscribed Emergencies Contingency Fund;
- [A71/INF./2](#) which reports on voluntary contributions by fund and by contributor, for 2017; much of the data reported on here is also included in [A71/28](#) in various infographics;
- [Tracker links](#) to discussions of 'strategic budget space allocation' for more information on how the PB is constructed; see PHM comment on Item 20.2 at WHA69 for more detail about how the budget is constructed; and
- the [WHO Budget Page](#) and [WHO PB Portal](#).

PHM Comment

The underfunding of WHO and the donor chokehold over the Secretariat's work program are shameful acts of global health vandalism. It has led to:

- critical limitations on Secretariat capacity to carry out its job;
- substantial distortions of the mandate of the governing bodies by the donors who choose what they will or will not fund and, because of the freeze on ACs, have almost total power over the budget; and
- exacerbation of silo behaviour and organizational fragmentation as units, clusters and regions compete for donor visibility and funding.

The % of the PB18-19 with assured funding is estimated to be 73% (at 31 March 2018); seriously unstable.

79% of WHO revenues were derived from VCs in 2017, 72% tightly earmarked. In view of the budget lines which have to be funded through ACs, this leaves the governing bodies with very little flexibility.

The alignment of the expenditure budget to global health priorities is skewed by the knowledge of what the donors will and will not fund. However, the actual funds mobilised for agreed budget lines is also very unbalanced. See Fig 1 for seriously underfunded budget lines.

PHM appreciates the efforts of the DG and Secretariat to mobilise funding and to do more with less. However, the agreed budget is ridiculously small - even if it were funded.

Member state delegates are urged to lift the freeze on the budget ceiling and lift the freeze on assessed contributions and untie their voluntary contributions.

17.1 Human resources: annual report

In focus

[A71/35](#) provides a commentary on the more detailed report presented in [Workforce data \(as at 31 Dec 2017\)](#). The commentary highlights:

- a slight increase in numbers;
- a slight decrease in number of staff on 'non-staff' contracts;
- a slight increase in the proportion of women in professional and higher categories with long term appointments;
- not much progress with respect to increasing the representation of people from developing countries at higher categories at Headquarters;
- strengthened outreach efforts to broaden talent source;
- new agreement aimed at increasing the number of volunteers working in WHO country offices;
- strengthened efforts to broaden the sourcing of WHO interns and to provide financial support to them;
- increasing geographical mobility of staff in professional and higher categories on long term appointments;
- close attention by DG to culture change and performance management;
- continuing action on respect, harassment, staff health and wellbeing, and internal justice.

Background

The quality of WHO's staff is critical to the work of the Organisation. A Revised Human Resources Strategy was adopted in 2014 ([EB134/INF./2](#)) and the HR report to WHA70 ([Annex to WHA70/45](#)) provides a detailed update on the implementation of the Revised Strategy.

The staff associations statement to the EB142 ([EB142/INF./1](#)) in Jan 2018 raised concerns about safety, access to health care and morale. Among the recommendations by the staff associations were:

- Create more core P1 and P2 positions. End the over-reliance on junior professional officers, consultants and interns for so-called entry-level work in the international professional category.
- Develop clear career pathways for colleagues working in the general service category. This should include routes of progression from general service to international professional or national professional officer. This would open up the opportunities for development and growth in staff's contributions to WHO.
- Pay interns and fellows a stipend, so that WHO can attract a diverse and highly qualified group of young professionals from around the world, particularly from low-income countries. Demonstrate to the world that WHO supports international labour standards. Access to internship should be based on merit, not on ability to pay.

See also [Tracker links](#) to previous HR reports, staff association statements and governing body discussions.

PHM Comment

Staffing flexibility in the face of financial uncertainty (due to donor unpredictability) and changing priorities needs to be balanced against the values of corporate memory and depth of technical expertise

Para 3 of the [HR Strategy](#) comments that

The main objectives are to ensure that the revised HR strategy supports WHO's strategic direction and priorities and responds to HR needs at all three levels of the Organization, taking into account WHO's financing model. To achieve these objectives, WHO needs a workforce that is more flexible, more mobile, highly performing, and fully trained and ready to take on new professional challenges.

In other words the abolition of continuing appointments and the pressures on staff to be more mobile are necessary strategies for adapting to the financial crisis and the uncertainties of donor dependence. The arguments which are offered in the Strategy for these provisions are clearly predicated upon the need to adapt to the financial crisis.

The proportion of WHO's total staff who are categorised as 'temporary' has increased from 20.3% in 2016 to 21.5% in 2017 (from Table 1 in HR Tables for [2016](#) and [2017](#)).

Commenting on the abolition of continuing appointments the staff associations' report to EB135 in May 2014 ([EB135/INF./1](#)) highlighted the need to balance managerial flexibility with technical depth and institutional memory. There is nothing in the Strategy or this annual report which shows how the Secretariat proposes to manage this balance.

PHM calls upon the member states to lift the freeze on assessed contributions; increase and untie voluntary donations and, in the words of the WHO Reform Stage 2 Evaluation (2013), to fulfill "their duty of care for the Organization, notably through adequate financing" ([EB134/39](#), p11).

Geographical balance

[WHA71/35](#) reports that 32% of MS are 'under represented in the international professional staff category. This is unchanged since 2017. See also Table 3 of the HR Tables which lists the MS identified as under- and over-represented as of Dec 2016. The US with 162 professional staff in the Secretariat is recorded as being under-represented.

The formula for determining that a country has the right number of professional staff (Resolution [WHA56.35](#)) gives great weight to the financial contribution of the country. This is inappropriate. The bias should be towards countries with needs for human resource development and high public health needs.

Interns and junior professional officers: exclusion of young people from L&MICs

Interns constitute around 10% of the human resources upon which WHO depends. Both interns and junior professional officers represent very promising pathways towards recruitment to formal employment.

In the case of both interns and junior professional officers, young people from low and middle income countries tend to be excluded. Access to internships requires independent funding. Access to JPO opportunities appears to be completely restricted to Europe and Japan. Given the commitment to 'diversity' in the Strategy this exclusion is not appropriate. PHM urges the inclusion in the HR Strategy provision for scholarships to support young people from L&MICs to access intern and JPO opportunities.

20.1 Global vaccine action plan

In focus

After a brief overview of the development of the Global Vaccine Action Plan (GVAP) [A71/39](#) conveys the Executive Summary of the [2017 Assessment Report](#) by the Strategic Advisory Group of Experts on the implementation of the Global Vaccine Action Plan.

Key points from the SAGE report:

- significant achievements recorded (wild polio, neonatal tetanus, measles, hepatitis B, development of national immunisation technical advisory groups (NITAGs), pricing transparency, Humanitarian Mechanism; see [SAGE,2017](#));
- however progress is too slow; under-performance in some countries and access to vulnerable populations are particular concerns;
- major challenges arise from economic uncertainty, conflicts and natural disasters, displacement and migration;
- weaknesses in immunisation delivery include: growing vaccine hesitancy and shortages and stockouts (causes vary: production, procurement, affordability, distribution; see [SAGE,2017](#));
- phase-out of polio funding with polio transition a big challenge.

Para 9 of Annex 1 of [A71/39](#) summarises the 12 recommendations of the Assessment Report.

[A71/39](#) also provides (in Annex 2) a summary of actions undertaken through WHO to implement resolution [WHA70.14](#) (May 2017) which called on member states to 'demonstrate stronger leadership and governance of national immunisation programs' as well as requesting the DG to continue to work in a range of areas to progress the achievement of the GVAP goals. The report highlights:

- monitoring and accountability;
- advocacy (political, technical, civil society);
- technical and financial support for NITAGs;
- research and development for new vaccines;
- vaccine prequalification ([about](#));
- joint procurement;
- temperature control and improved delivery;
- pricing initiatives.

The Secretariat's [GVAP website](#) and the [GVAP indicator portal](#) provide access to much very useful information.

The report of the October 2017 meeting of the SAGE (in [WER,92,729-748](#)) provides further useful information.

Background

The Global Vaccine Action Plan (GVAP) was adopted by the WHA in [WHA65.17](#) in May 2012.

[WHA65.17](#) requested annual update reports. In [A66/19](#) the Secretariat proposed a draft framework for monitoring, evaluation and accountability for GVAP which was endorsed by the Assembly (in May 2013).

The first update report ([A67/12](#)) on the implementation of GVAP was considered by the Assembly in May 2014 in [A67/12](#).

A further report was considered by WHA68 in 2014 in [A68/30](#) and the Assembly adopted a further resolution [WHA68.6](#) which strengthened the GVAP in certain respects including requesting the Secretariat to collect and present data on vaccine pricing.

In May 2016 the Assembly considered [A69/34](#) which included a report on GVAP generally and specifically on the implementation of [WHA68.6](#) which was noted by the Assembly

In May 2017 the Assembly considered (in [A70/25](#)) the Executive Summary of the Midterm GVAP (2010–2020) review by the SAGE (full report [here](#)). Responding to the SAGE report the Assembly adopted resolution [WHA70.14](#).

(Many of the themes developed in the 2016 Assessment Report / mid term review are reiterated in the 2017 Assessment Report.)

See [Tracker links](#) to previous governing body discussions of the GVAP and PHM comments.

PHM Comment

The various SAGE reports are thorough and comprehensive, both with respect to analysis and strategy and need to be fully implemented. However, PHM urges member states to give special priority to the following issues.

Price

Price remains a major barrier to the full achievement of the GVAP goals. This is particularly so for countries transitioning out of GAVI eligibility ([SAGE,2017](#)) and for those losing part of their immunisation workforce with the polio transition. A number of countries have experienced the Gavi 'graduation trap': implementation of new and expensive vaccines under GAVI support followed by the need for full funding upon GAVI graduation.

We highlight the [call by Gambia](#), speaking on behalf of the Afro Region at EB140, for WHO to further explore the recommendations of the [UN HLP on Access to Medicines](#) with a view to finding new ways to fund vaccine development and production.

See also:

[WHO \(2017\)](#). Vaccine pricing: GAVI transitioning countries

[Torreele, E. and M. Mazzucato \(2016\)](#). "Fair vaccine pricing please, not random acts of charity." *BMJ* 355.

[Editorial \(2015\)](#). "Global harmonisation in vaccine price." *The Lancet Infectious Diseases* 15(3): 249.

[MSF \(accessed 2018\)](#). A Fair Shot

Technology transfer

PHM urges MSs to give close attention to the challenges of domestic manufacturing in developing countries including technology transfer and obstacles to obtaining licensure or prequalification status (see [submission](#) by the Developing Countries Vaccine Manufacturers Association (DCVMN) to the SAGE October 2017 meeting).

National / regional immunization technical advisory groups (NITAGs)

PHM appreciates the increasing number of countries with functioning NITAGs (or regional bodies). Capacity building for NITAGs is a high priority. Likewise the need for rigorous conflict of interest provisions, transparency with regard to their deliberations and political/parliamentary accountability for the implementation of their recommendations. See [Global Nitag Network](#).

The opportunity costs of adding new or 'under-used' (but expensive) vaccines to national schedules need to be considered closely by NITAGs. The decision to introduce new vaccines must be based on country specific epidemiology, health system capability, and financing. For this reason the capacity of NITAGs to undertake these analyses is of critical importance to the implementation of GVAP.

NITAGs also need to monitor community confidence and investigate the causes of growing 'hesitancy'. Rigorous and systematic post-marketing surveillance is a precondition for community confidence.

NITAGs also need to develop fine grained district and community data to monitor geographic equity in access to immunisation. Under-immunisation of difficult to access populations should not be obscured by averages.

Health system strengthening

Immunisation performance, including geographic equity, is dependent on whole of health system performance. Immunisation coverage is a valid and reliable indicator of health system capacity generally and in particular the implementation of primary health care principles. The paradox is that attempts to boost immunisation coverage through vertical stand alone programs risk weakening the implementation of comprehensive primary health care and thus constitute a limit on immunisation performance. WHO and member states need to continue to focus attention on health system strengthening.

20.3 Progress reports

In focus

[A71/41](#) reports on the implementation of the following resolutions:

Communicable diseases

- A. Global health sector strategies on HIV, viral hepatitis and sexually transmitted infections, for the period 2016–2021 ([WHA69.22](#) (2016))
- B. Eradication of dracunculiasis ([WHA64.16](#) (2011)); previous reports [here](#);
- C. Elimination of schistosomiasis ([WHA65.21](#) (2012), [A68/36](#) (PR2015))

Noncommunicable diseases

- D. Public health dimension of the world drug problem ([WHA70\(18\)](#) (2017))
- E. Global burden of epilepsy and the need for coordinated action at the country level to address its health, social and public knowledge implications ([WHA68.20](#) (2015))
- F. Comprehensive mental health action plan 2013–2020 ([WHA66.8](#) (2013), [A68/36](#) (PR2015))
- G. Comprehensive and coordinated efforts for the management of autism spectrum disorders ([WHA67.8](#) (2014), [A68/36](#) (PR2015))

Promoting health through the life course

- H. Global strategy and action plan on ageing and health 2016–2020: towards a world in which everyone can live a long and healthy life ([WHA69.3](#) (2016))

Health systems

- I. Promoting the health of refugees and migrants ([WHA70.15](#) (2017))
- J. Strengthening integrated, people-centred health services ([WHA69.24](#) (2016))
- K. Promoting innovation and access to quality, safe, efficacious and affordable medicines for children ([WHA69.20](#) (2016))
- L. Sustainable health financing structures and universal coverage ([WHA64.9](#) (2011), [A65/26](#) -PR2012)
- M. Availability, safety and quality of blood products ([WHA63.12](#) (2010), [A67/40-PR2014](#))
- N. Human organ and tissue transplantation ([WHA63.22](#) (2010), [A67/40-PR2014](#))
- O. WHO strategy on research for health ([WHA63.21](#) (2010), [links to previous reports](#))
- P. Workers' health: global plan of action ([WHA60.26](#) (2007), [A66.27](#))

Health emergencies programme

- Q. Smallpox eradication: destruction of variola virus stocks ([WHA60.1](#) (2007), [links](#) to previous progress reports)

Corporate services/enabling functions

- R. Multilingualism: implementation of action plan ([WHA61.12](#) (2008), [links](#) to previous progress reports)